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Enhancing the Performance of Local
Long-Term Care Ombudsman Programs
in Ohio: Chartbook

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Enhancing the Performance of Local Long-Term Care Ombudsman Programs in Ohio

CHARTBOOK

June 2008

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Funded by The Cleveland Foundation and conducted in collaboration with
C.L. Estes & colleagues at the University of California, San Francisco.

OVERVIEW

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Overview of the Study

Following the completion of the *Enhancing the Effectiveness of Local Long-Term Care Ombudsman Programs in New York and California* project, other states expressed an interest in replicating the project. In Ohio, under a collaborative agreement, researchers at the Scripps Gerontology Center at Miami University were the lead agency in using the structure and survey instrument created by researchers at the Institute for Health & Aging (IHA) at the University of California, San Francisco. Our goal was two fold: 1) to replicate the New York and California projects in order to advance comparative knowledge of program performance and barriers across the nation; and 2) to identify and examine Long-Term Care Ombudsman Program (LTCOP) issues of particular relevance to Ohio. Throughout this endeavor we have had superb cooperation and support from the State Ombudsman Program of Ohio, under the direction of Beverly Laubert.

The Ohio state study benefits from collaboration between Chris Wellin and Cary S. Kart, of Miami University's Scripps Gerontology Center, and Dr. Carroll Estes and colleagues at the Institute for Health & Aging (IHA) at the University of California, San Francisco. Dr. Estes is a national authority on the Ombudsman Program and a member of a task force convened by the Institute of Medicine some years ago to examine the viability and performance of the LTCOP nationally. Drs. Wellin and Kart conducted in-person survey interviews with all of the LTCOP program directors in the state—10 persons who are responsible for 12 Planning and Service Areas or “PSAs.” (Two respondents have responsibility for two regional programs each; inasmuch as they face different issues and have different host agencies in each PSA, we interviewed them twice). Thus we have a 100% response rate. The survey instrument is detailed and comprehensive in addressing organizational, programmatic, and policy issues that are germane to the ability of regional Program Directors to meet their various mandated responsibilities. The charts presented here, in which we summarize and display our findings, are comparable to those in the New York/California Comparative chartbook, and in a just published Illinois study.

OVERVIEW

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Overview of the Study, cont'd.

In the Ohio case study, our major goals were to:

- Identify the specific factors (activities, resources, roles and organizational characteristics- including location of the host agency) that are associated with program effectiveness in Ohio;
- Develop a set of actionable recommendations specifically for the Ohio Ombudsman Program (A Blueprint for Action);
- Work with local ombudsman programs and the Ohio State Ombudsman in developing steps to strengthen their programs;
- Promote communication and enhance synergy between state and local ombudsman entities in Ohio; and
- Disseminate findings and best practices to Ohio LTCOPs from other states and from Ohio to LTCOPs in other states, using the internet and appropriate state and national organizations and meetings.

OVERVIEW

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Overview of the Study, cont'd.

As part of a multi-state effort to improve the ability of local ombudsman programs to assist residents of long-term care (LTC) facilities to resolve complaints and problems regarding quality of care, the Ohio LTCOP project will both contribute to and benefit from the larger project. The comparison of issues confronting local Ohio ombudsmen programs with those confronted in similar programs across six geographically, demographically, and politically diverse states will be informative in identifying and sharing information regarding best practices, and program strengths and weaknesses. The project is committed to the application of findings through the development of a Blueprint for Action (a strategy for improving the Local LTC Ombudsman Program), the Ombudsman Summit, and at least one key policy event in Ohio. The overall multi-state project is intended to contribute to dialogue at both the state and national levels concerning future programmatic and policy directions and deliberations concerning the continuing re-authorization (in 2011) of the Older Americans Act and the Ombudsman Program.

Regional ombudsman programs in Ohio are housed in a variety of host agencies – Area Agencies on Aging (6), Catholic Social Services (2), legal services (2), Lutheran Metropolitan Ministry (1), and government ombudsman office (1). The impact of organizational placement on effective advocacy is not well understood. Shedding light on the nature and impact of this is a major goal of this study. Regional programs formed the Ohio Association of Regional Long-Term Care Ombudsmen (OARLTCO) in 1984. OARLTCO's activity has waxed and waned through the twenty years of their organization and effectiveness is dependent on the elected officers. Another factor in their degree of organization and advocacy seems to be the leadership of the State Ombudsman and existence or lack of organizational constraints at the state level. The Blueprint for Action informed by this project should provide guidance to the State Ombudsman with regard to working effectively with the association and how the relationship with the association does or should differ from the relationship with individual programs. Ohio has a fairly large urban area and large number of older persons with a high percentage residing in nursing homes. Adding Ohio to the Local LTCOP Project has enhanced the regional variation of the project and increased knowledge on a comparative state basis within it.

METHODS

1

Project Methods

The project had two phases. Phase 1 involved collaboration between researchers from the Miami University Scripps Gerontology Center and from the Institute for Health & Aging at the University of California, San Francisco, and state and local LTC leaders to implement the research study. Phase 2 was devoted to eliciting reactions from informants, and to developing recommendations and generalized dissemination as well as targeted follow up with LTC policymakers and other critical stakeholder groups.

Meetings to discuss findings and implications were planned from the outset, in keeping with a developmental, participatory research design. The purpose of these meetings is to strengthen and disseminate the study's recommendations. One, an Ombudsman Mini-Summit in February of 2007 in Columbus, brought regional ombudsmen together to discuss study findings and consider how to define and implement key project recommendations. Because Program Directors are most knowledgeable about, and directly involved in, administering the LTCOP, their perspectives were the focus of our first meeting. In the second meeting, which took place in May 2007, we shared findings from ten "Informed Respondent" interviews, and from analysis of secondary data gleaned from a mandated online reporting system. The second meeting included, in addition to Program Directors, various state policymakers and other critical stakeholders who will be instrumental in developing a framework (Blueprint) for implementing policy and programmatic improvements. In these meetings we were alert to areas of consensus, as well as expressed differences—in philosophy, perspective, or strategy—among groups who have a shared stake and distinct roles in the LTCOP of Ohio. After submitting this report to the Cleveland Foundation, we will begin planning for a more public "summit" (time, location, and sponsorship to be announced) in which we can consider implications of the study for state and regional policy, and disseminate findings to relevant actors in the academy, healthcare sector, policy-realm, and government.

INTRODUCTION

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Background

On April 21st of this year, the *New York Times* published an article by Robert Pear entitled “Oversight of Nursing Homes is Criticized.” The article drew on a report—soon to be released by a Congressional oversight committee—of the effectiveness of federal health regulators in protecting the safety and dignity of the approximately 1.5 million Americans who reside in the nation’s 16,000+ nursing homes. The report focused on the most questionable nursing homes, those that have been found repeatedly to violate basic standards of care and safety. It concluded that serious fines and penalties are rarely imposed, even for the least compliant homes, and that sanctions are “generally so small that nursing homes view them as a cost of doing business, with no more effect than a slap on the wrist.”

Clearly, as our society ages, the reliance on long-term care for the frail and disabled will increase, a trend that will continue despite the relatively lower rates of disability projected for the “baby boomer” cohorts. In Ohio, a demographically aging state, the challenge of providing safe, high-quality long-term care is especially acute. According to a recent report, “The population most likely to be in need of long-term care, those age 85 and above, has increased by almost 50,000 (34%) since 1990. As if today’s challenges are not enough, projections indicate that the 85-plus group will increase from the current 184,000 to over one million by 2050 when the baby boomers reach old age” (Mehdizadeh & Applebaum 2003, p. 1). Also, relatively low birth rates in recent years predict that there will be fewer adult children to provide care for disabled elders.

It is important to note that “long-term care” encompasses more than nursing homes: in fact, in Ohio as elsewhere, the LTC system’s greatest expansion is *not* in nursing homes and other skilled medical facilities, but rather in various community-based models and alternative institutional settings such as assisted living/residential care and home health services. Thus the challenge of monitoring the quality and safety of long-term care in centralized, medically-oriented settings is compounded by the fact that, today, residents are: a) more widely dispersed geographically and b) more likely to be found in settings in which regulatory standards are less clear and less stringent than is true in nursing homes. Our challenge is to achieve greater flexibility of care and resident autonomy, in a manner that preserves residents’ rights, dignity, and responsible government oversight.

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Focal Areas of Research Attention in the Comparative Study

Ohio's LTCOP works to improve the lives of everyone who receives long-term care services. Mandated under the federal Older Americans Act, Long-Term Care Ombudsman Programs play an important role in the quality of care of older residents of LTC institutional settings and community living arrangements by advocating to protect the health, safety, welfare, and rights of elderly and other residents. Specifically, LTCOPs address five federally mandated activities and roles including: complaint investigation; community education; resident and family education; monitoring federal, state and local law, regulations and other government policies and actions; and legislative and administrative advocacy.

It may be useful here briefly to sketch the major topical areas we addressed in the study. These are areas that have been found to affect program effectiveness in prior research: *(1) adequacy of and control over resources; (2) organizational autonomy; and (3) inter-organizational relationships and coordination.*

The first area encompasses staffing, budgetary pressures, and the stability of these crucial resources for particular local programs over time. The second topical area reflects the variation in "host agencies" among local LTCOPs. At the inception of the program nationally, it was generally believed not to be ideal for local programs to be housed in Area Agencies on Aging. There were concerns regarding potential conflicts of interest for Long-Term Care Ombudsmen (LTCOs), inasmuch as clients would likely be participating in programs administered through the AAA. More generally, researchers have investigated whether the level of support for the mission of the LTCOP, and various kinds of technical and legal support, vary according to where (in which kind of agency) local programs are housed. Finally, as a program that spans federal agencies and mandates, state-level programs, and local relationships with social service and legal entities, LTCOPs require ongoing coordination across these boundaries and jurisdictions. Research has sought to identify the nature and quality of such coordination.

A final area of substantive interest in our study is the ability of LTCOPs (given current staffing and budgetary resources) to respond to systemic shifts in the long-term care system. In Ohio, as nationally, this shift has involved greater demand for and provision of long-term care in settings such as residential care/assisted living facilities, adult care homes (often independent and owner-occupied), and home health care. The emergence of more community-based options is widely-regarded as a positive and overdue development in the continuum of care in the U.S. However, given that community-based settings are both geographically more dispersed, and less tightly-regulated, than custodial/nursing institutions, we need to examine what new demands and pressures this set of changes may be imposing on regional LTCOPs.

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Program Characteristics

Program Directors in Ohio have considerable tenure and experience; nearly three-quarters reported five or more years of service in their current position (Figure 2.1). In fact, the same proportion report ten or more years of *total* experience, which reflects earlier involvement as volunteers and/or other roles (Figure 2.2). About half of Ohio's local programs are located in Area Agencies on Aging, with the remainder divided between multi-purpose non-profit agencies (2); legal services agencies (2) or stand-alone non-profit agencies (1) [Figure 2.3]. Nearly half of local programs report having fewer than 5 volunteers, and only one-quarter report having more than 10 (Figure 2.5). It will be important to assess the adequacy of volunteer staff in relation to the particular PSAs in which programs are located (which vary greatly in the size, diversity, and density of their populations). Three-quarters of respondents report needing additional funding to carry out all mandates (Figure 3.3), and the same proportion disagree that they have sufficient paid staff on hand (Figure 3.4). Local program directors report strong support in host agencies, with two-thirds perceiving that the LTCOP is recognized as a priority by the host agency (Figure 3.7).

INTRODUCTION

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Self-Rated Effectiveness

As Figure 3.1 indicates, regional program directors rate highly their effectiveness in handling complaint investigation (with 83% rating themselves as “very effective”), while fewer (25%) rate their effectiveness in resident and family education; community education; and monitoring federal, state, and local laws and regulations as “very effective”. Only 8% rate their “legislative and administrative policy advocacy” as very effective. Also, program directors rate their effectiveness in nursing homes more highly than they do in residential care/assisted living facilities; 67% and 50%, respectively, rate themselves as “very effective” in the two settings (Figure 3.2).

The patterns reported above reflect a serious underlying issue, which is the extent to which LTCOPs have sufficient funding, staff, and technical support to carry out their state and federal mandates. Staffing and budgetary constraints have been a perennial problem for these programs, as they are more generally for health and social services in the public sector. However, as we document elsewhere in this report, what *has* changed is the scope and intensity of resident concerns as the long-term care system in Ohio evolves to accommodate societal aging.

As Figure 3.3 reveals, 75% of respondents report a need for additional funding in order to carry out all mandates; the same percentage disagree that their program has a sufficient number of paid staff to meet their demands (Figure 3.4). In turn, nearly 60% of program directors claim they lack sufficient volunteer staff to meet resident mandates (Figure 3.4). In line with their traditional, mandated emphasis on resolving resident complaints, regional ombudsmen report having to neglect other priorities that are central to the broad mission of the program. For example, a third of respondents report not being able to fully engage in resident and family education, and 42% report having to neglect or minimize community education and the monitoring of federal, state, and local laws and regulations (Figure 3.5). Nearly all, 92%, say they are “often or always unable” to engage in legal and administrative policy advocacy, which is a potentially powerful public function (Figure 3.5). We feel this last issue is especially important given what is a well-funded and – organized lobbying presence on behalf of long-term care providers in Ohio.

INTRODUCTION

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Study Special Issue Domains

Informants rate highly their effectiveness in addressing complaints and concerns regarding elder physical abuse, with nearly 60% believing they are “very effective” in this arena; fewer (25%) rate as highly their capacity to address gross neglect, and one-third (33%) rate their ability to address financial exploitation as “very effective” (Figure 4.1). Earlier we noted the systemic shift in Ohio’s long-term care system; in addition to more residents in residential care and assisted living, we see more “short-term” nursing home residents, who are receiving post-acute, rehabilitative, and convalescent care. Only 17% of respondents report feeling “very effective” in meeting the needs of such residents, and 75% perceive themselves to be “somewhat effective” in this regard (Figure 4.4). Clearly, LTCO’s ability to inform residents and to monitor the more intensive, often technologically-elaborate treatment involved in post-acute and rehabilitative care, is shaped both by the compressed time duration for such care, and the degree of familiarity of LTCO staff (both volunteer and professional staff) with these medical and therapeutic regimens.

List of Figures

A NOTE ABOUT DATA PRESENTATION: *This state-level case study is one of several that have been, or are being, carried out across the country. We were obliged, by our funder and PIs in other states to follow uniform conventions of presentation. Though it is questionable to report percentages for such a small “N” we have done so to facilitate comparisons between states.*

Figure 2.1: Years of Experience in Current Position as an Ombudsman

Figure 2.2: Years of Total Experience as an Ombudsman

Figure 2.3: Location of Regional LTCOPs

Figure 2.4: Number of Paid Program Staff (Full-Time Equivalents) in Regional LTCOPs

Figure 2.5: Number of Certified Volunteer Staff in Regional LTCOPs

Figure 2.6: Number of Volunteers, 2005-2006 (Average of 2005 Designation & Service Review Summaries and 2006 Ombudsman Registry)

Figure 2.7: Ratio of Nursing Homes and Residential Care Facilities Served by the Regional LTCOPs

Figure 2.8a: Percentage of Nursing Home Beds in the Regional LTCOPs

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Figure 2.12a: Total Budget Dollars from Federal and State Sources, FY2005

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Figure 2.13: Ratio of Regional LTCOP Budget Dollars for Each LTC Facility

Figure 2.14: Ratio of Regional LTCOP Budget Dollars per LTC Bed

Figure 2.15: The Top Five Most Frequently Closed Complaints by Facility/ Service Type, 2005

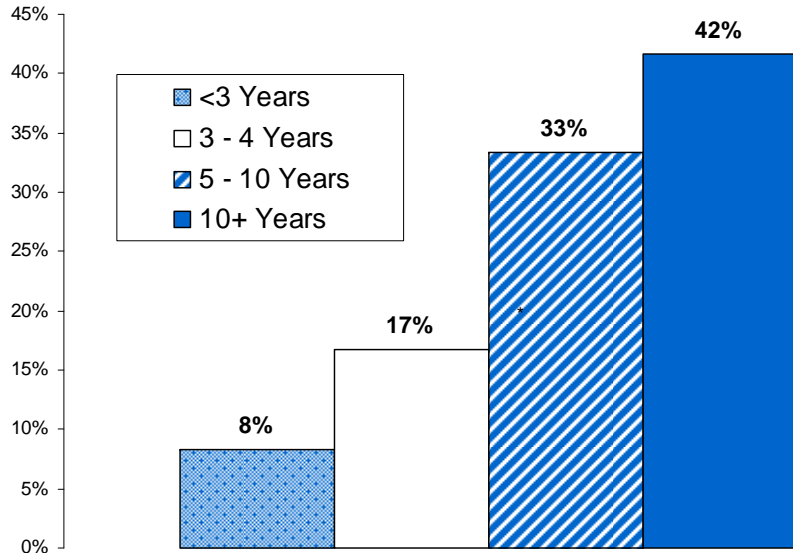
Figure 2.16: Percentage of Complaints Resolved for Regional LTCOPs

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Figure 2.18: Ratio of Regional LTCOP Budget Dollars per Closed Complaint

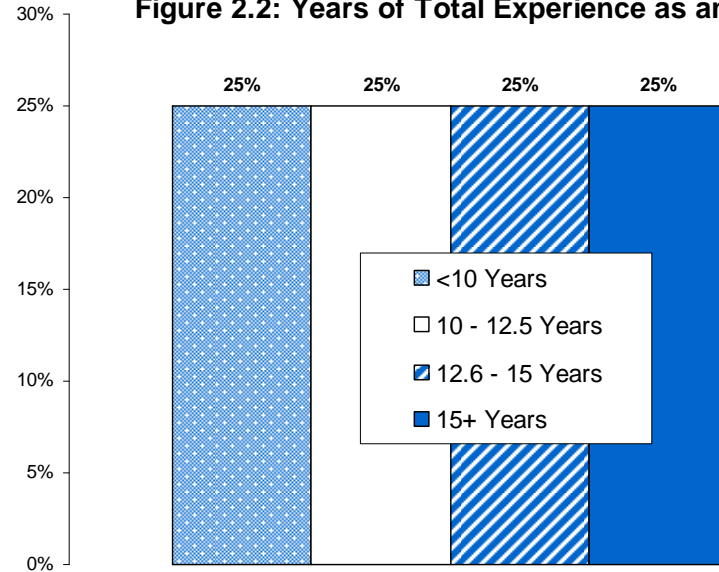
Characteristics of LTC Ombudsman Program Coordinators

Figure 2.1: Years of Experience in Current Position as an Ombudsman



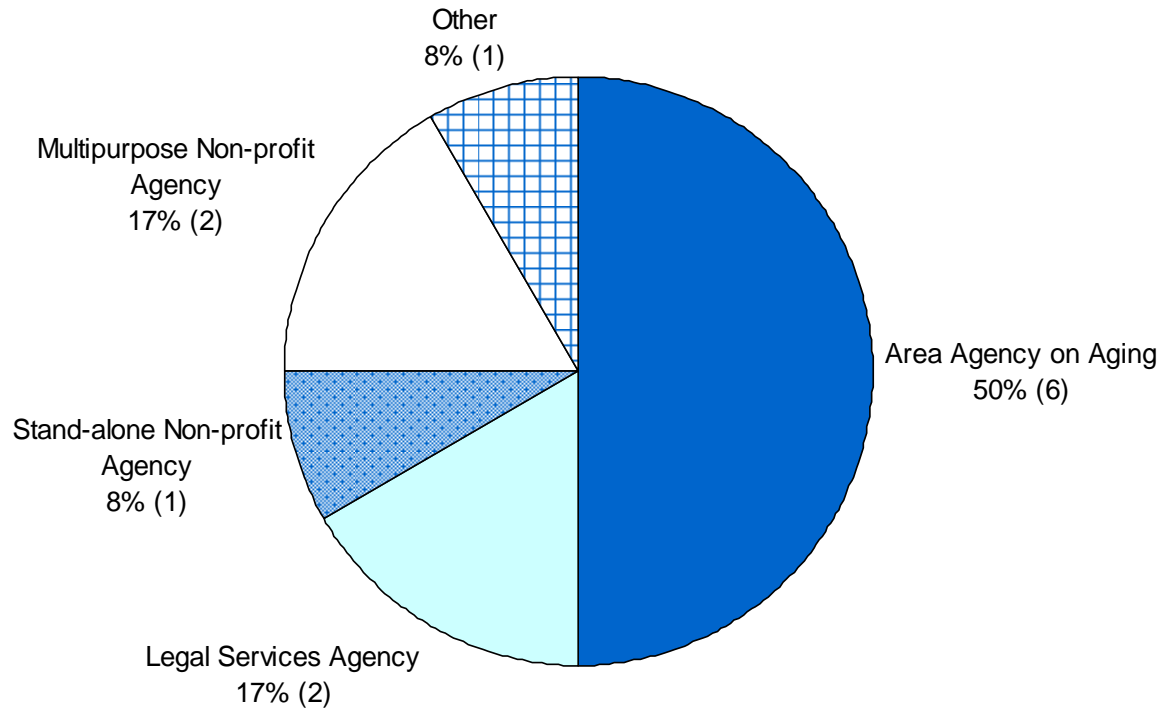
Q. How long (in years) have you been in your current position as an Ombudsman?
 Respondents' duration in current position as an Ombudsman ranged from 1.0 to 19.5 years, with a mean of 9.167 years

Figure 2.2: Years of Total Experience as an Ombudsman



Q. How many years total experience do you have as an Ombudsman, including years in your current position?

Respondents have years of total experience as an Ombudsman ranging from 1.0 to 23.0 years, with a mean of 12.375 years (sd = 5.593). The median years of total experience as an Ombudsman is 12.75 years.

Figure 2.3: Location of Regional LTCOPs

Q. Which of the following most accurately describes the host agency of your local LTCOP? [A "host agency" is the organization in which your LTCOP is located or agency that sponsors your LTCOP.]

Six of the 12 LTCOPs (50.0%) are hosted by an Area Agency on Aging. Eleven of the 12 regional LTCOPs described their host agencies as "private non-profit" and none (0) report having had a change in the host agency in the last five years.

Staffing of Local Long-Term Care Ombudsman Programs

Figure 2.4: Number of Paid Program Staff (Full-Time Equivalents) in Regional LTCOPs

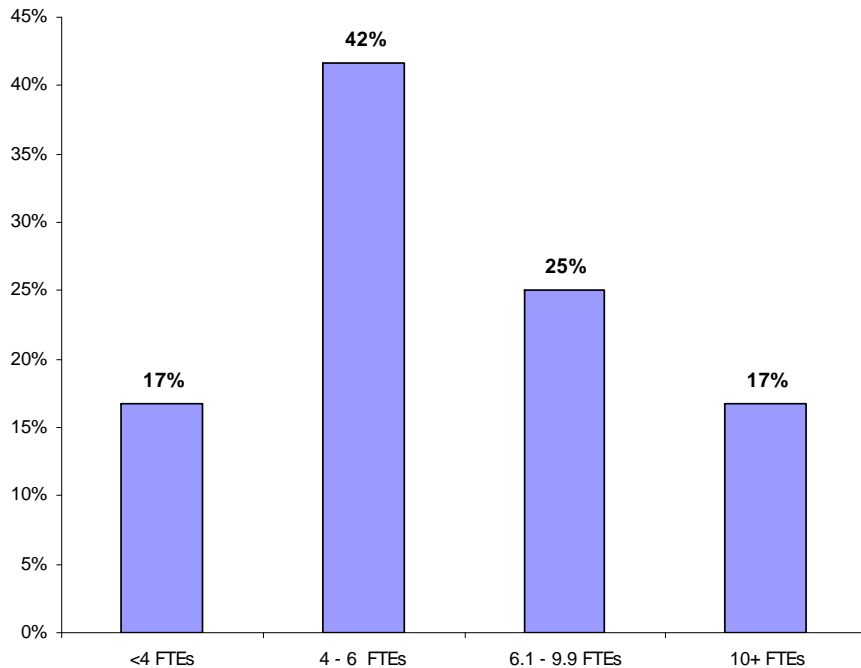
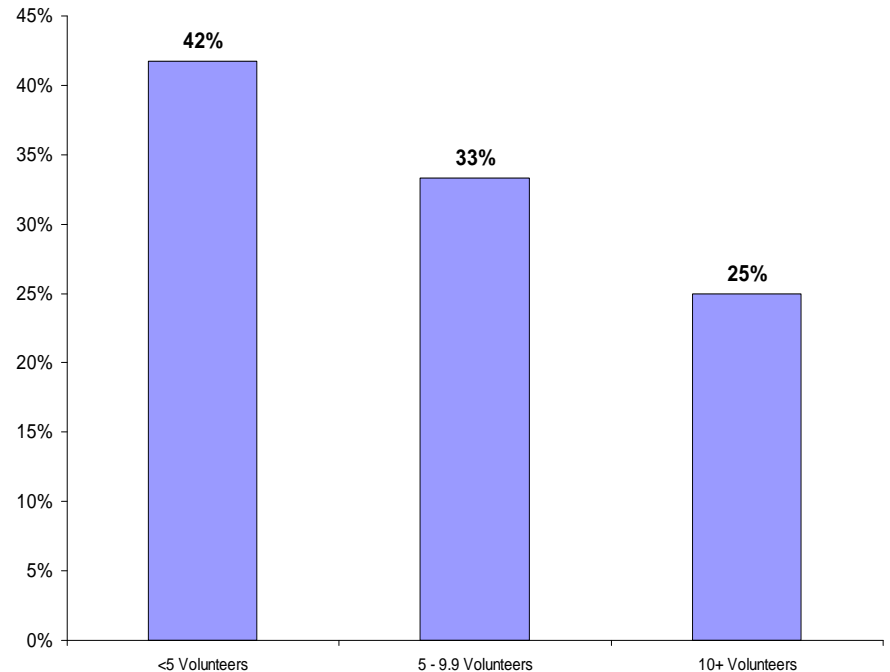


Figure 2.5: Number of Certified Volunteer Staff in Regional LTCOPs

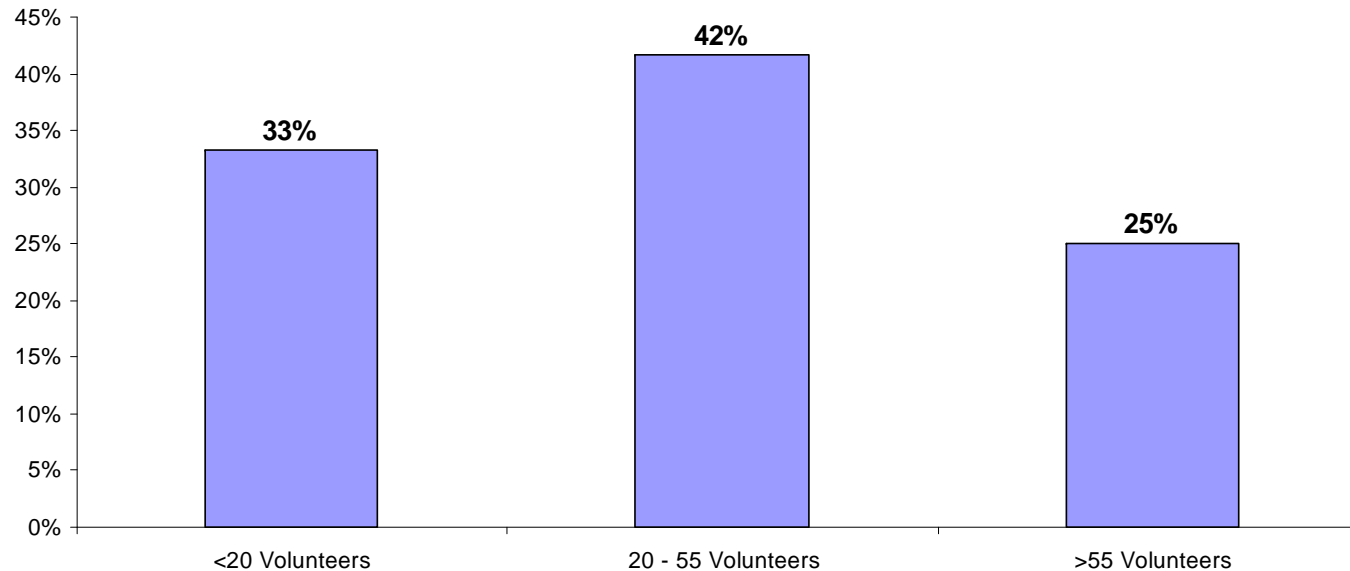


The number of certified volunteer staff at the regional LTCOPs ranged from 2.0 to 13.0 with a mean of 6.42 (sd = 3.502), and a median number of certified volunteer staff of 5.0.

Paid program staff (FTEs) at the regional LTCOPs ranged from 2.0 to 13.0, with a mean of 6.158 FTEs (sd = 3.144) and a median number of 5.5 FTEs.

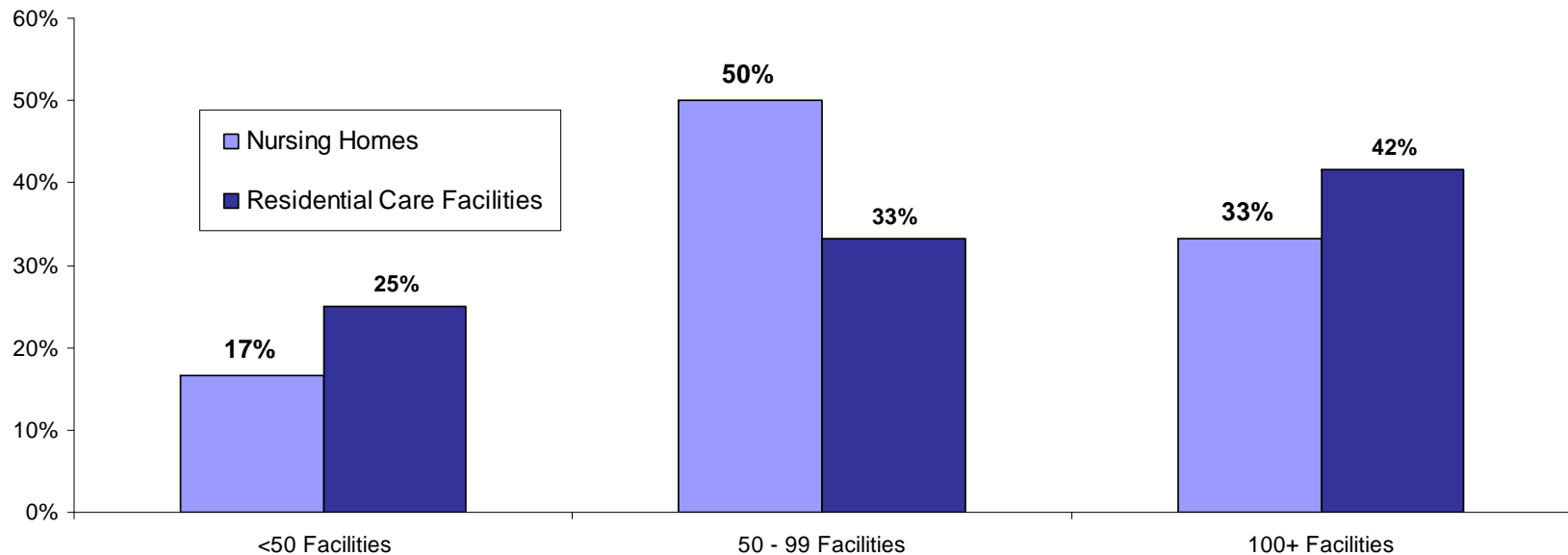
Staffing of Local Long-Term Care Ombudsman Programs, cont'd

Figure 2.6: Number of Volunteers, 2005-2006 (Average of 2005 Designation & Service Review Summaries and 2006 Ombudsman Registry)



The average number of volunteers reported by the regional LTCOPs across 2005-2006 is 42.00 (sd = 26.861), with a median = 42.50 and a range from 7.00 to 93.50.

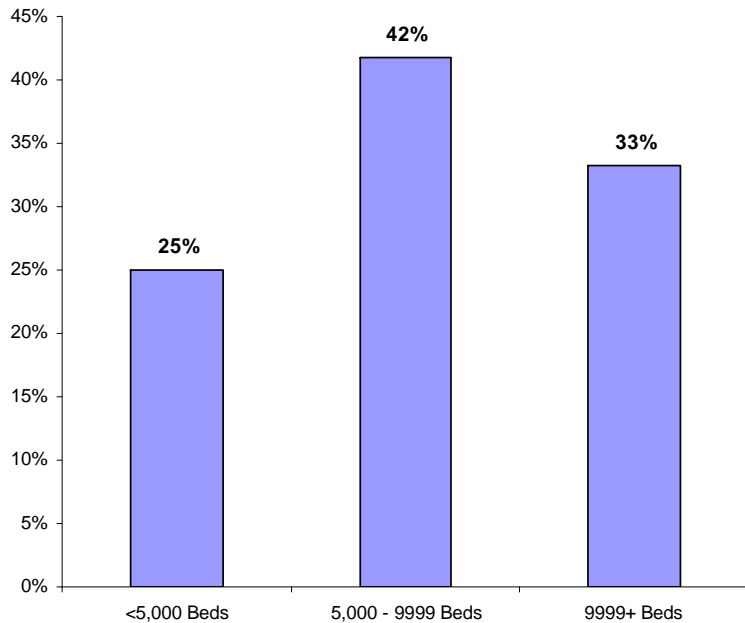
Figure 2.7: Ratio of Nursing Homes and Residential Care Facilities Served by the Regional LTCOPs



The regional LTCOPs vary widely with regard to the number of nursing homes and residential care facilities (includes assisted living) they serve, although there is a strong positive correlation between the two ($r = .959$). On average, a regional LTCOP in Ohio serves 84 nursing homes ($sd = 37.803$), but this ranges from 23 to 164 nursing homes. The average LTCOP serves 100.50 residential care facilities ($sd = 74.199$), with a range from 12 to 282 facilities.

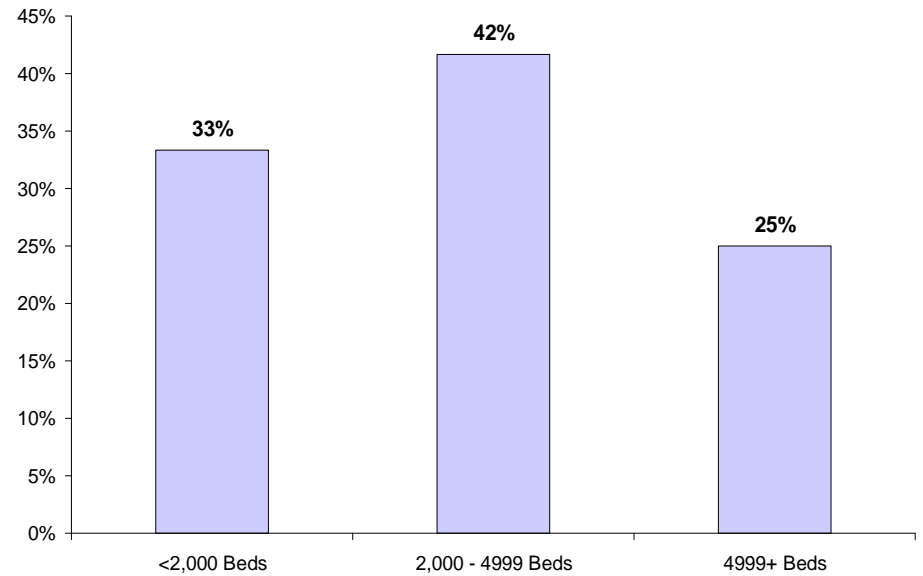
Nursing Home and Residential Care Beds

Figure 2.8a: Percentage of Nursing Home Beds in the Regional LTCOPs



The regional LTCOPs vary sharply with regard to the number of nursing home beds they serve. This ranges from 2148 to 18,422 beds, with an average of 8226.75 (sd = 4560.117) and a median of 8094 nursing home beds.

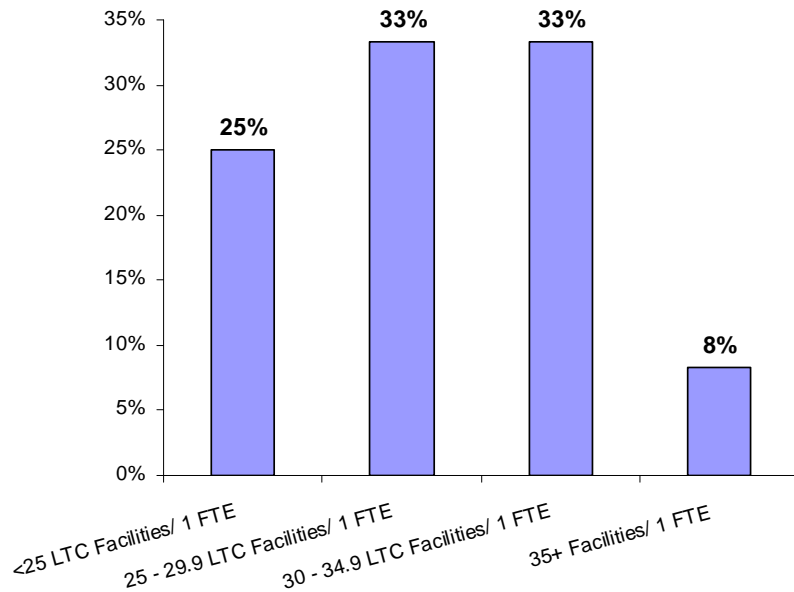
Figure 2.8b: Percentage of Residential Care Beds in the Regional LTCOPs



The average number of residential care beds in a regional LTCOP in Ohio is 3621.83 (sd = 2474.487), with a median of 3050. The regional LTCOPs vary sharply, however, with a low of 512 and a high of 9079 residential care beds.

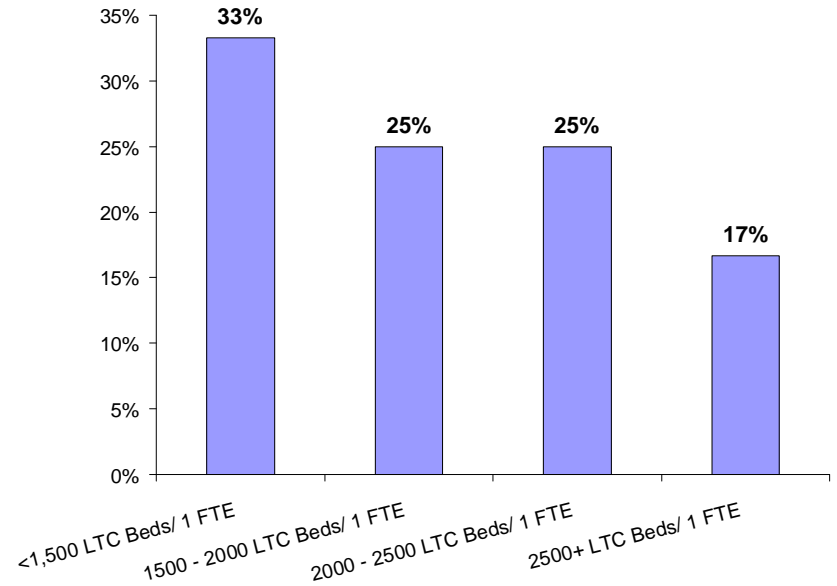
Ratio of LTC Facilities and Beds to Full-Time Equivalent Staff

Figure 2.9: Ratio of LTC Facilities (Nursing Home and Residential Care Facilities) to Full-Time Equivalent Staff



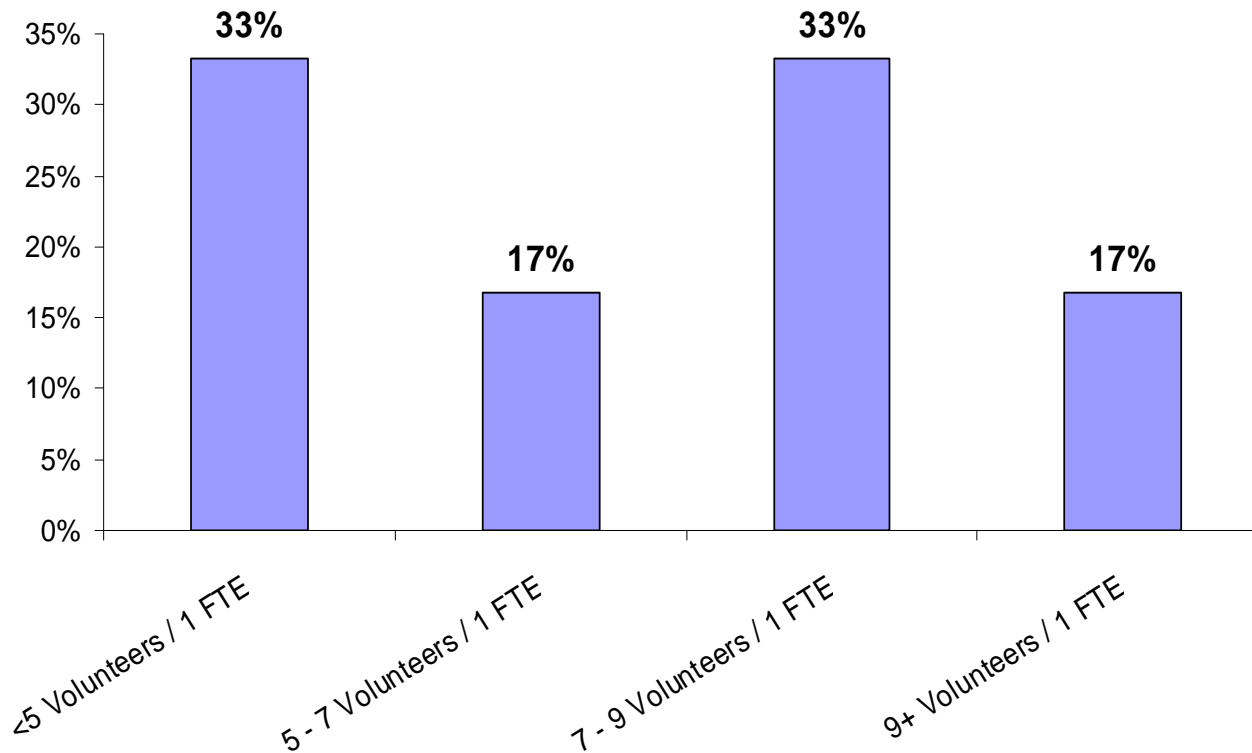
As we have already noted, the regional LTCOPs vary widely in paid staff as well as the number of long-term care facilities (nursing homes and residential care facilities) which they serve. On average, a regional LTCOP in Ohio has one staff FTE for each 28.845 facilities it serves (sd = 6.289), with a range in values from a low of 17.50 to a high of 41.00 facilities for each FTE.

Figure 2.10: Ratio of LTC Beds (Nursing Home and Residential Care Facilities) to Full-Time Equivalent Staff



The regional LTCOPS also vary widely in the ratio of staff FTEs to long-term care beds, with a range of one staff FTE for 1330 beds on the low end and 2627.75 beds on the high end. On average, the LTCOPs in Ohio show a ratio of 1 FTE per 1869.916 beds (sd = 449.870) and a median of 1 FTE per 1718.779 beds.

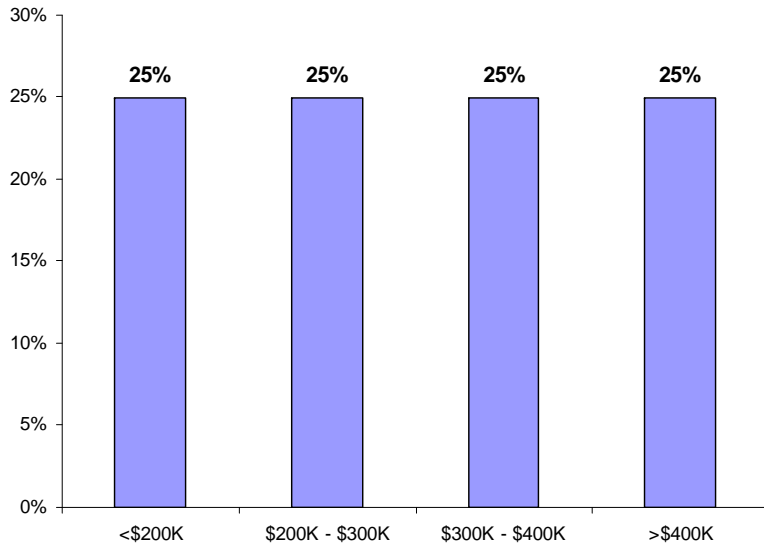
**Figure 2.11: Ratio of Volunteers (2005-2006)
to Full-Time Equivalent Staff**



As we have already seen in Figure 2.5, the regional LTCOPs in Ohio vary in their numbers of certified volunteer staff. They vary as well in terms of the ratio of volunteers to FTE staff with a range from 2.06 volunteers/FTE to 10.17/FTE (mean = 6.415, sd = 2.542).

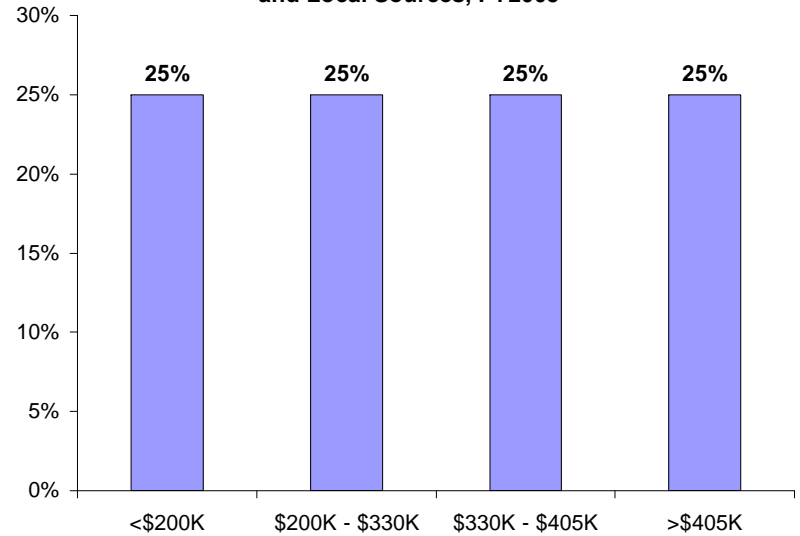
Budget Dollars

Figure 2.12a: Total Budget Dollars from Federal and State Sources, FY2005



Regional LTCOPs in Ohio differ in size and geographic location. As a result, the budget dollars they receive from federal and state sources varies widely. Although the average budget amount from these sources is \$346,302 for FY2005 (sd = \$218,796), the median amount is \$295,018 and the range is from \$122,952 to \$903,004.

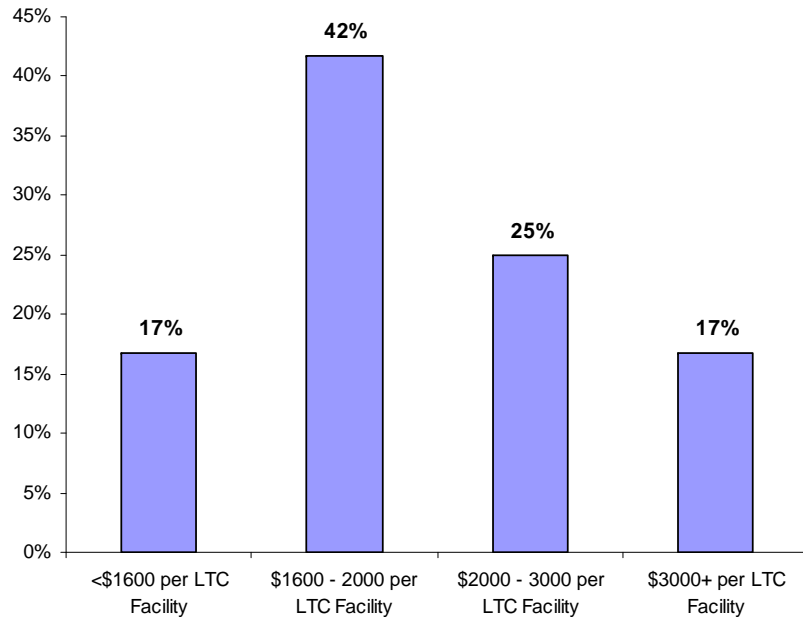
Figure 2.12b: Total Budget Dollars from Federal, State and Local Sources, FY2005



For the regional LTCOPs in Ohio, budgets are very much a function of the federal and state support they receive. Five of the 12 LTCOPs report no local contribution to their budgets. The average total budget dollars available to the LTCOPs is \$386,571 (sd = 283,033), with a median of \$328,024 and a range from \$122,952 to \$937,514.

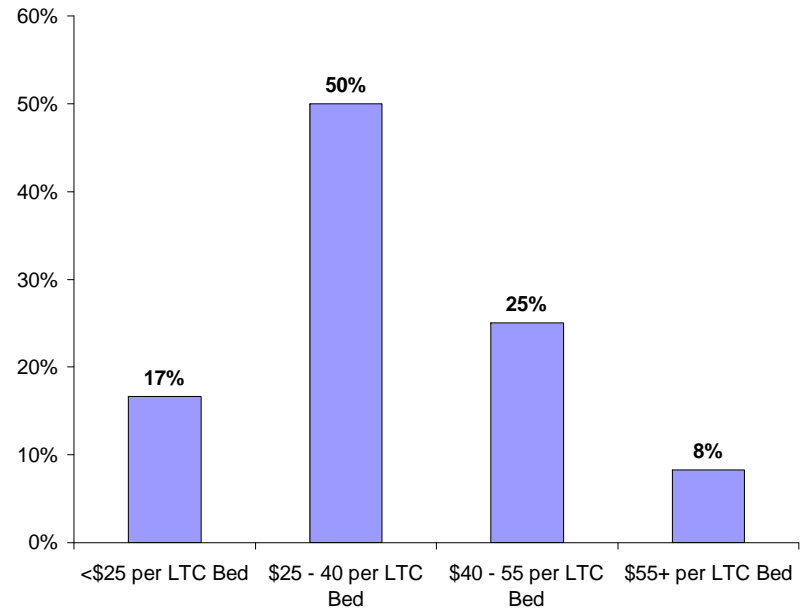
Budget Dollars, cont'd.

Figure 2.13: Ratio of Regional LTCOP Budget Dollars for Each LTC Facility



The regional LTCOPs in Ohio differ in the average total dollars in their budget for each LTC facility they serve. Across the regional LTCOPs, the mean total budget dollars is \$2242/LTC facility (sd = \$768) with a range of \$1520 to \$3765/LTC facility.

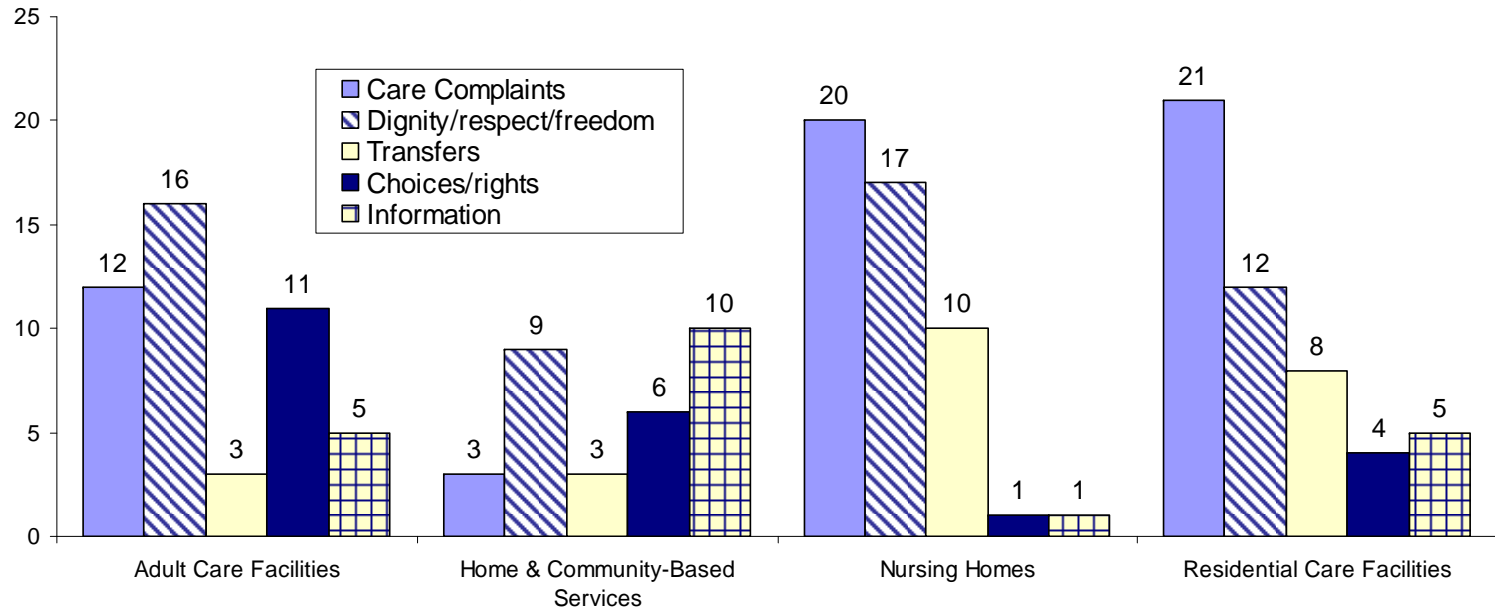
Figure 2.14: Ratio of Regional LTCOP Budget Dollars per LTC Bed



Also as a function of budget dollars, the regional LTCOPs show wide variation in budget dollars/LTC bed they serve. With a range from \$22/LTC bed to \$63/LTC bed, the mean is \$35/LTC bed (sd = \$13).

Complaints

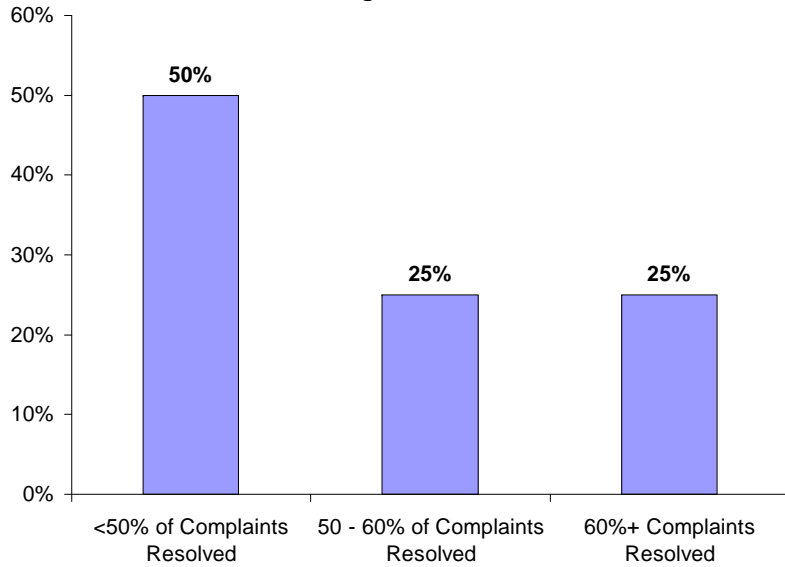
Figure 2.15: The Top Five Most Frequently Closed Complaints by Facility /ServiceType, 2005



This data provided by the State Office of the Ohio Ombudsman is based on listings of the five most frequent “closed complaints” in each regional LTCOP. The category labels are intended to represent groups of complaints around a common theme. In Ohio’s adult care facilities, nursing homes, and residential care facilities, as well as with home & community-based services, in 2005, the five most commonly closed complaints include “care complaints,” complaints about “dignity, respect and freedom,” and complaints about “transfers.” “choices/rights.” and “information.”

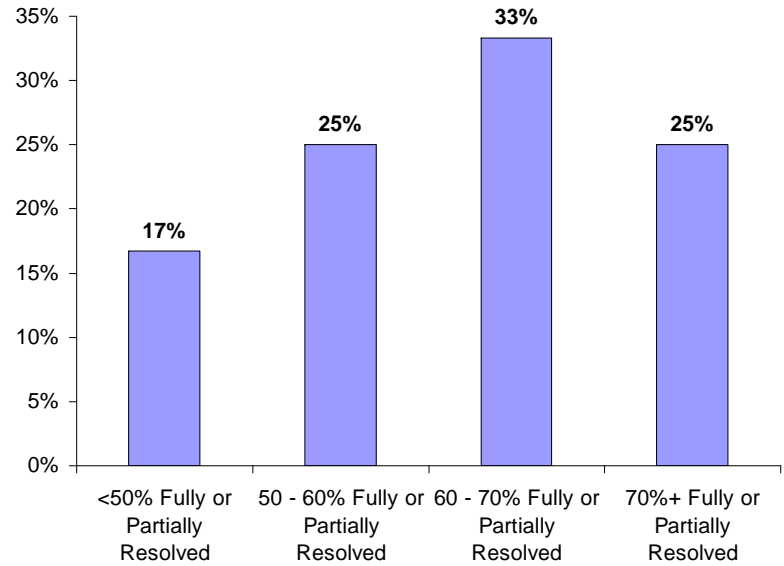
Resolution of Complaints

Figure 2.16: Percentage of Complaints Resolved for Regional LTCOPs



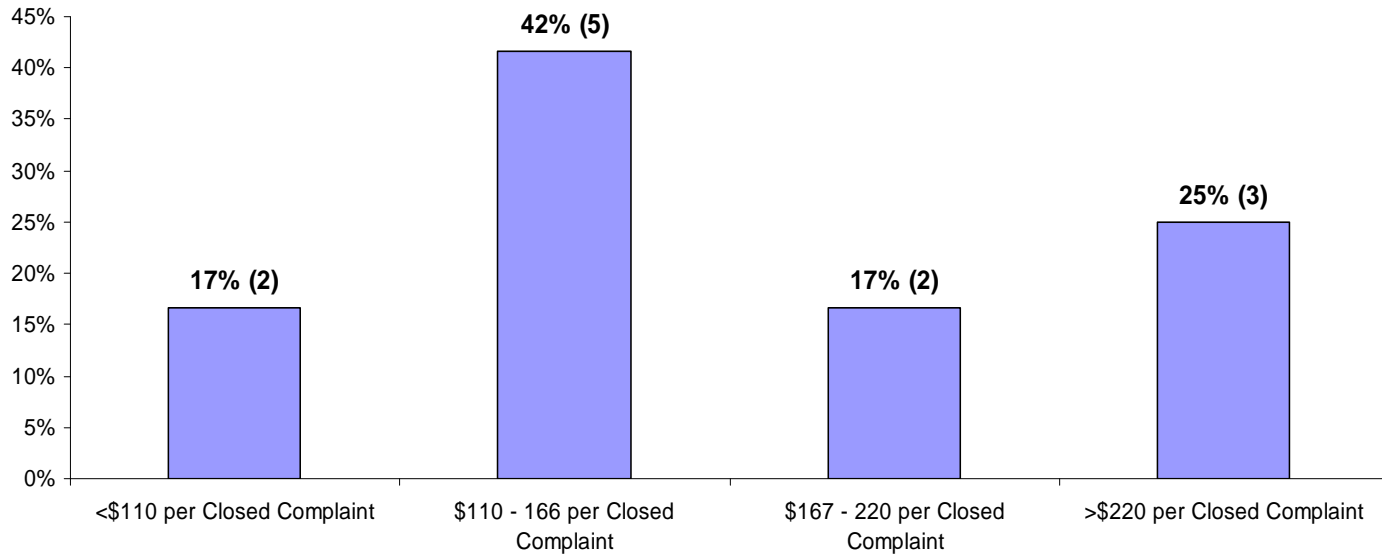
Across the regional LTCOPs, the average percentage of complaints resolved is 52.933 (sd = 9.286), with a median percentage of 51.55 and a range varying from 40.6% to 65.8%.

Figure 2.17: Percentage of Complaints Fully or Partially Resolved for the Regional LTCOPs



As Figure 2.17 above shows, on average, a majority of complaints received by the regional LTCOPs are completely resolved. However, for a variety of reasons, some complaints are only partially resolved. The average percentage of complaints either partially or completely resolved ranges from 44.4% to 72.1%, with a mean of 60.717 (sd = 9.424).

Figure 2.18: Ratio of Regional LTCOP Budget Dollars per Closed Complaint*



*Assumes that approximately one-third of a regional LTCOP's total budget is available for complaint resolution.

Dollars expended in FY2005 to close complaints varied widely among the regional LTCOPs with costs ranging from \$89 to \$265 per closed complaint. The average cost per closed complaint was \$177 (sd = \$59) with median expenditure at \$158.

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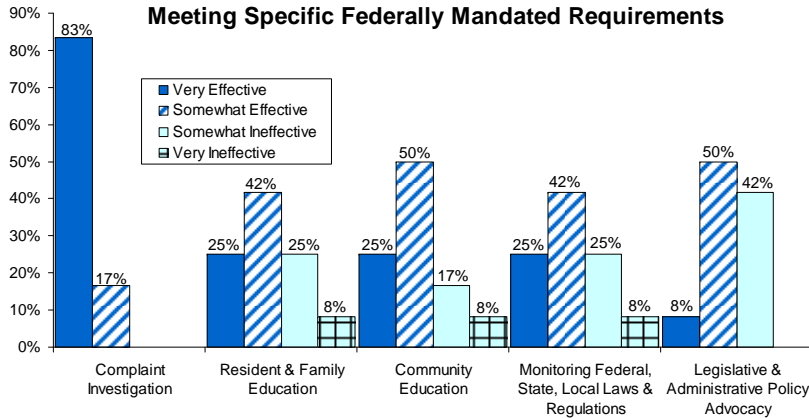
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Self-Rate Effectiveness

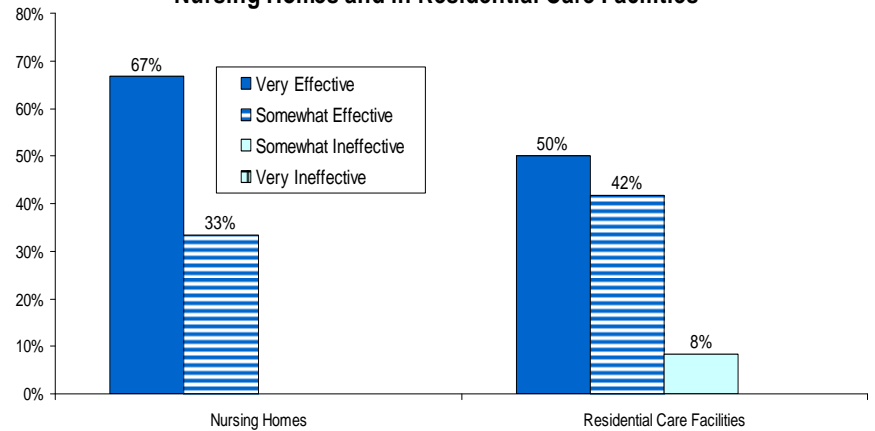
Figure 3.1: Self-Rated Effectiveness of Regional LTCOPs in Meeting Specific Federally Mandated Requirements



Q. How would you rate the effectiveness of your local LTCOP's performance in meeting the specific federally mandated requirements?

Ombudsmen rated their LTCOP's performance in complaint investigation as effective with 83.3% (N = 10/12) rating performance as "very effective." Although a majority of the ombudsmen similarly rated the performance of the other federally mandated requirements as very and/or somewhat effective, in each case at least 25% of the ombudsmen rated these requirements as "somewhat" and/or "very ineffective." Most noteworthy among these, in assessing "legislative and administrative policy advocacy," 41.7% of the ombudsmen rated performance as "somewhat ineffective."

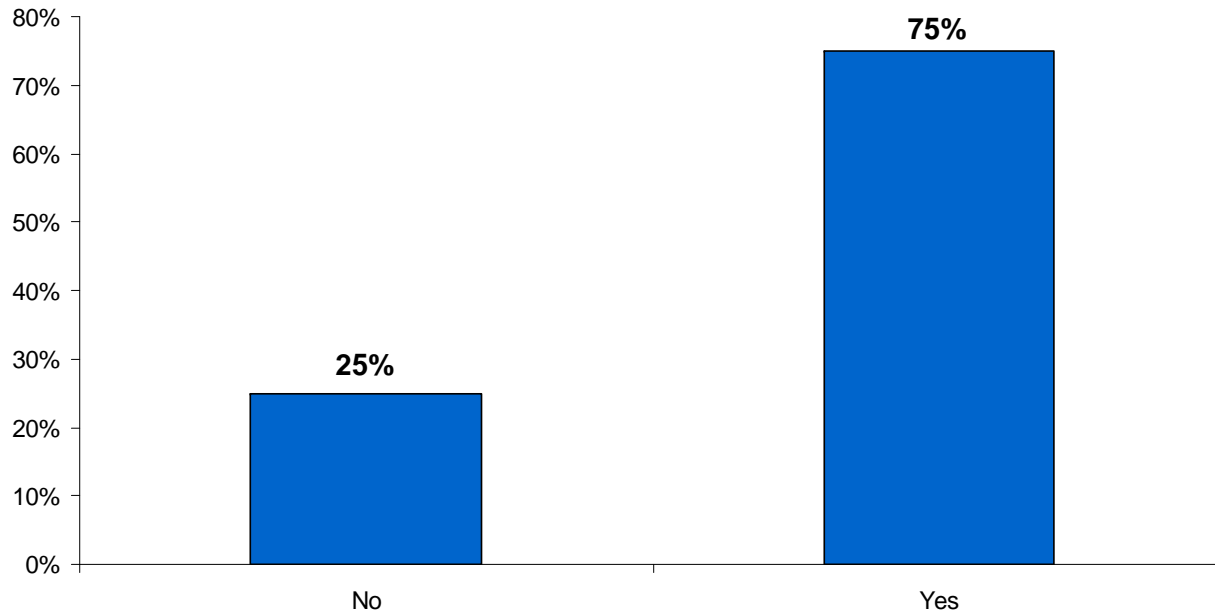
Figure 3.2: Self-Rated Effectiveness of Regional LTCOP Performance in Nursing Homes and in Residential Care Facilities



Q. Overall, how would you rate your local LTCOP's performance with each of the following settings?

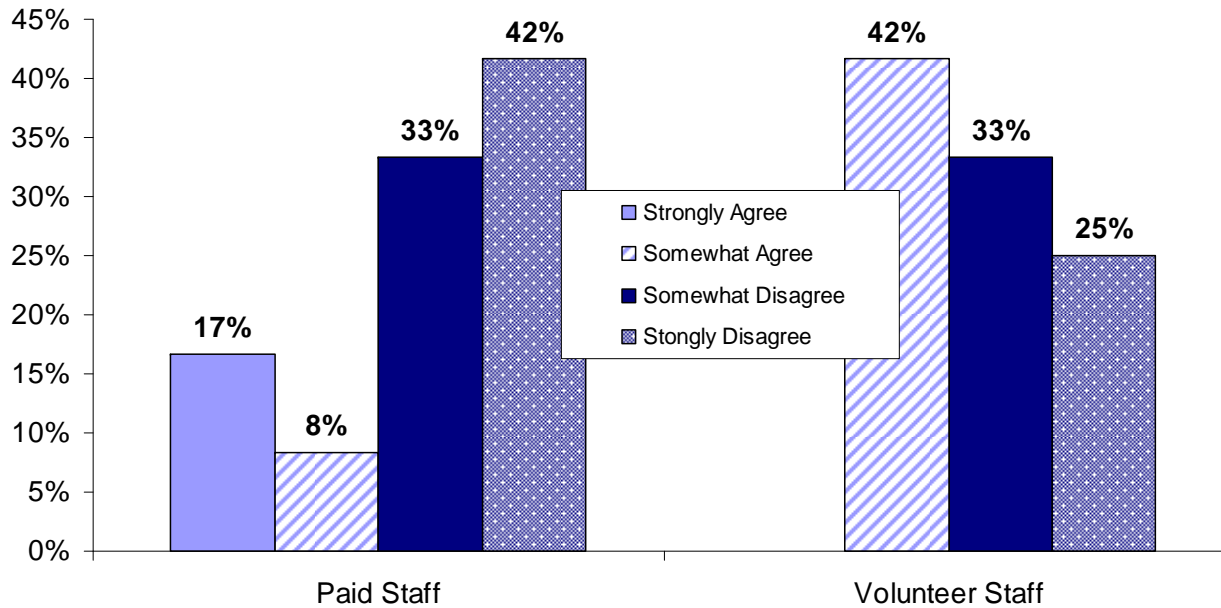
Ombudsmen rated their program's overall performance as more effective in nursing homes than in the array of settings encompassed by the residential care facilities label; 66.7% vs. 50.0% rated LTCOP performance as "very effective" in the respective settings. One ombudsman even assessed program performance in residential care facilities as "somewhat ineffective."

Figure 3.3: Does the Regional LTCOP Need Additional Funding to Carry Out All Mandates?



Q. Does your local LTCOP have a sufficient amount of funding to carry out all of its State and Federal mandates?
Most of the ombudsmen (75%) reported needing additional funding to carry out their program mandates.

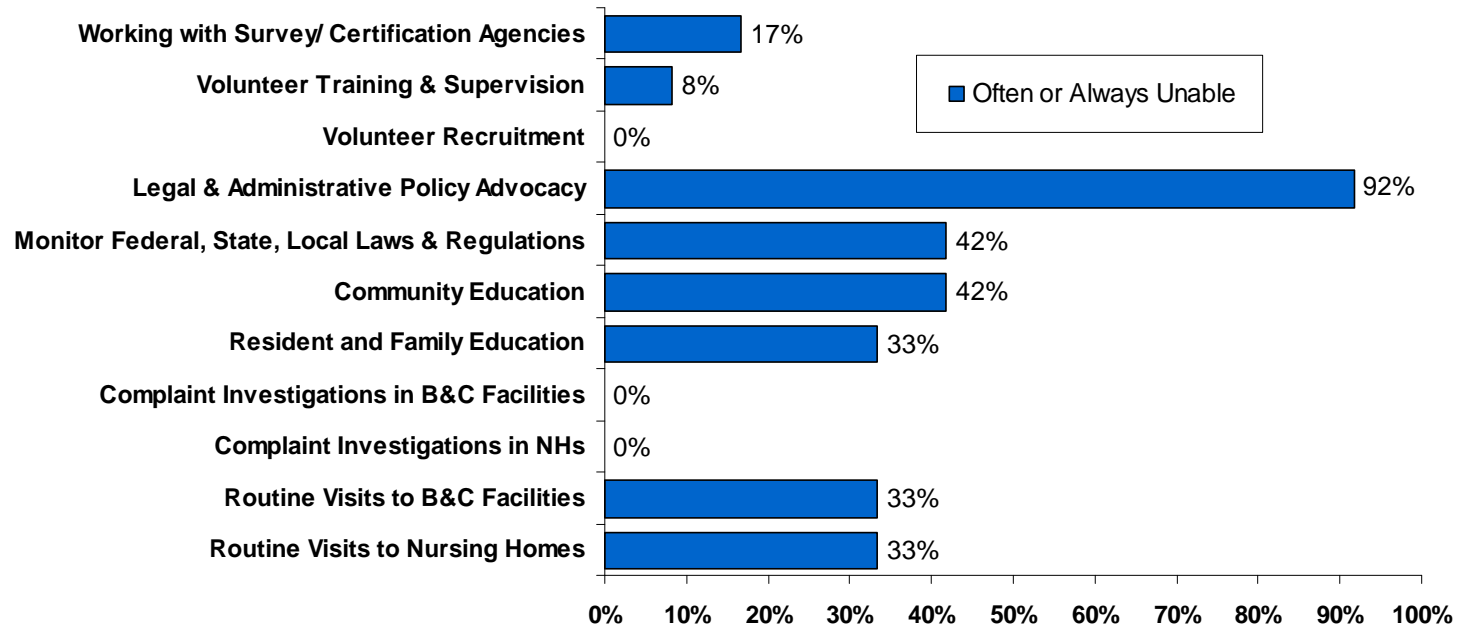
Figure 3.4: Extent to Which Regional LTCOP Coordinators Perceived Their Program to Have Sufficient Numbers of Paid Staff and Volunteer Staff



Q. To what extent do you agree with the statement, your local LTCOP has a sufficient number of paid and volunteer/unpaid staff?

A majority of ombudsmen perceived that their programs have insufficient paid staff (75% disagreed either “somewhat” or “strongly” with the statement above) and volunteer/unpaid staff (58% disagreed).

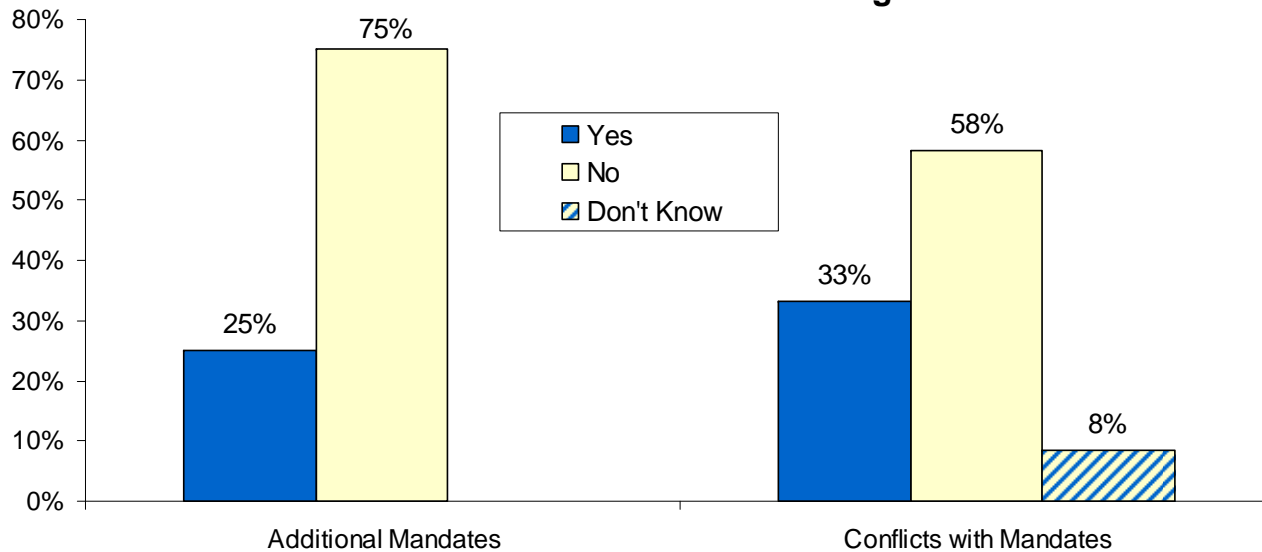
Figure 3.5: Self-Reported LTCOP Activities Neglected or Partially Carried Out Because of Lack of Resources



Q. What activities, if any, has your local LTCOP been unable to adequately perform because of lack of resources or funds?

Noteworthy is that 92% (N = 11/12) of the ombudsmen report that legal and administrative policy advocacy is often or always unable to be carried out as a result of a lack of resources; 42% of the ombudsmen (N = 5/12) report similarly about often or unable being able to do community education and monitor federal, state and local laws and regulations.

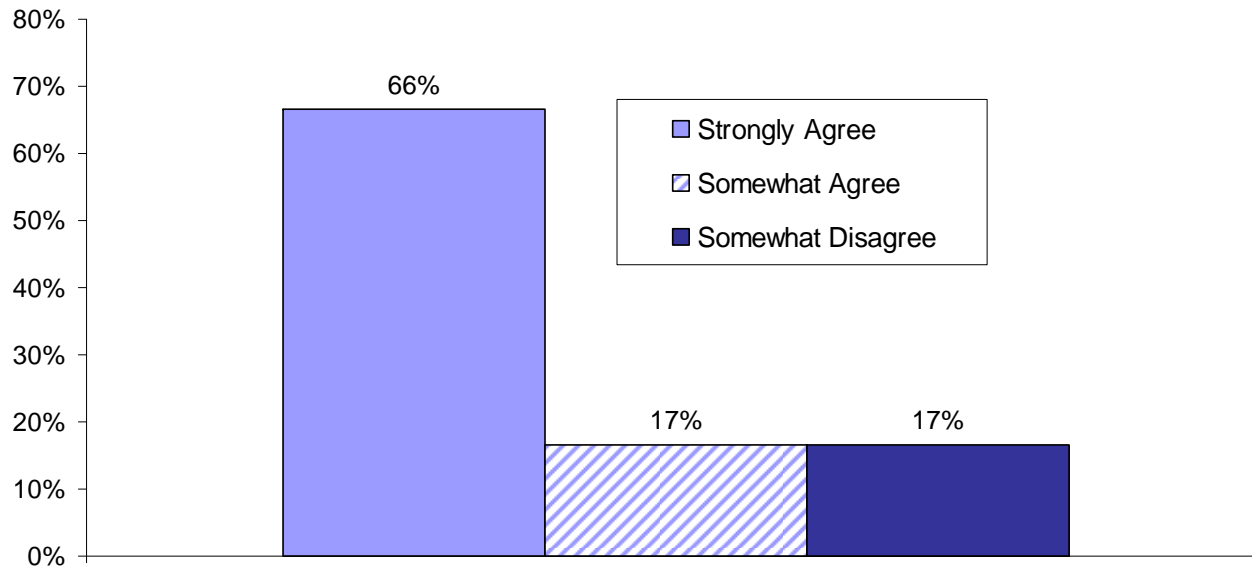
Figure 3.6: Extent to Which Regional LTCOP Coordinators Perceived Additional Mandates or Conflicts with Mandates that Added to the Workload of the Program



Q. Are there any additional state mandates, either funded or unfunded, that add to the workload of your local LTCOP? Do you have any state laws, regulations, or agency agreements that conflict with the ability of your local LTCOP to carry out its federal or state mandates?

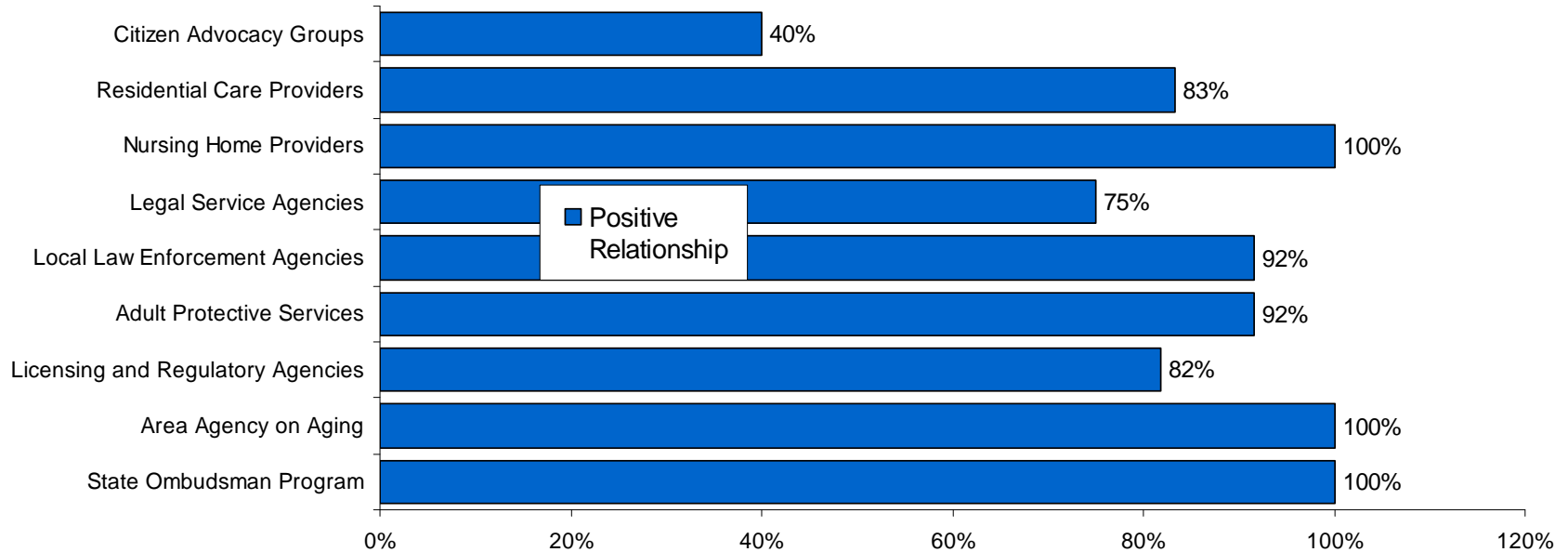
Three-of-four (75%) ombudsmen identify additional mandates that add to program workload, whereas 58% (N = 7/12) identify conflicts with mandates that increase program workload.

Figure 3.7: Extent to which Regional LTCOP Coordinators Perceive That Their Regional Program is Recognized as a Priority by the Host Agency



Q. To what extent do you agree with the statement, your local LTCOP is recognized as a priority by your host agency? Most program coordinators (N = 10/12) perceive that their host agency recognizes the regional LTCOP as a priority.

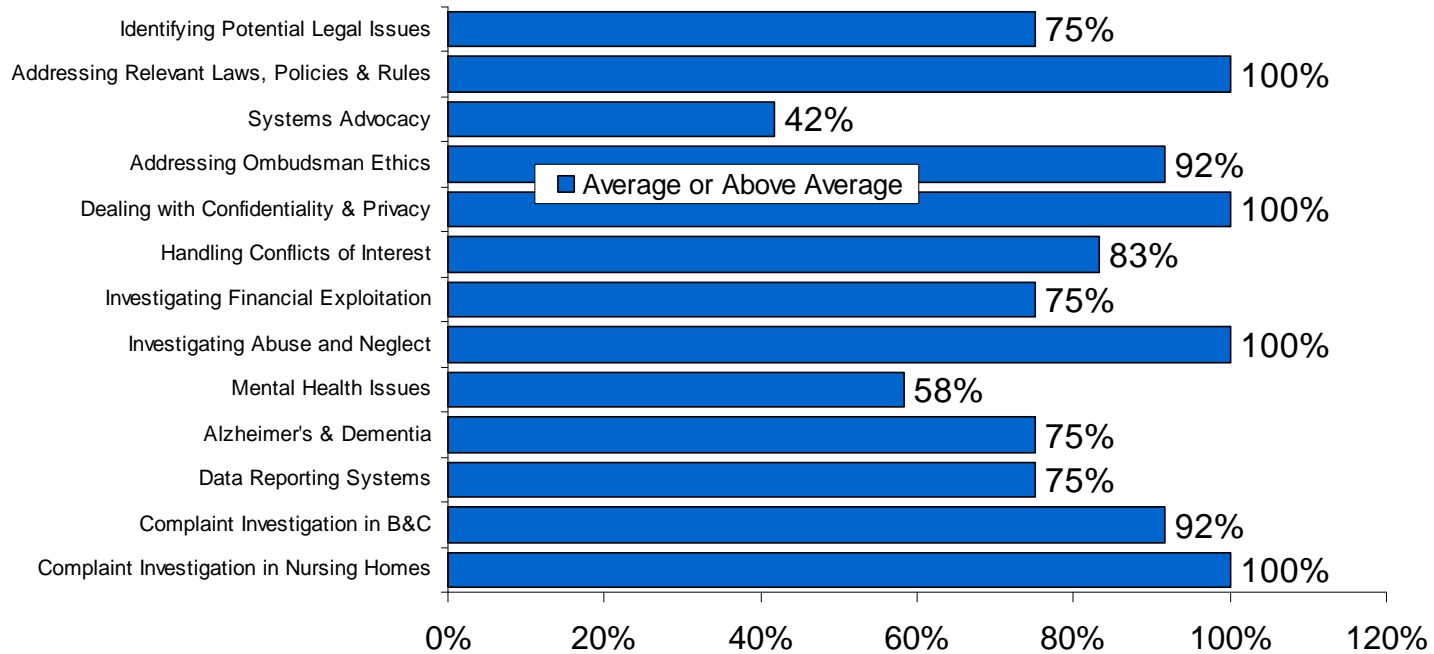
Figure 3.8: Extent to Which LTCOP Coordinators Perceive a Positive Relationship with Other Organizations/ Agencies



Q. To what extent do you agree with the following statement, Overall your LTCOP has a good working relationship with your ...?

With one exception, program coordinators perceive that the LTCOP has a positive working relationship with other organizations and agencies. This seems especially the case for nursing home providers, area agencies on aging and the state ombudsman office, where 100% of program coordinators perceive a positive working relationship. Only 40% of LTCOP coordinators perceive a positive working relationship with citizen advocacy groups in their region, with a number of coordinators being unable to identify any such agencies.

Figure 3.9: Percentage of Satisfactory Ratings for Training Provided in Specific Content Areas for Regional LTCOP Staff Members



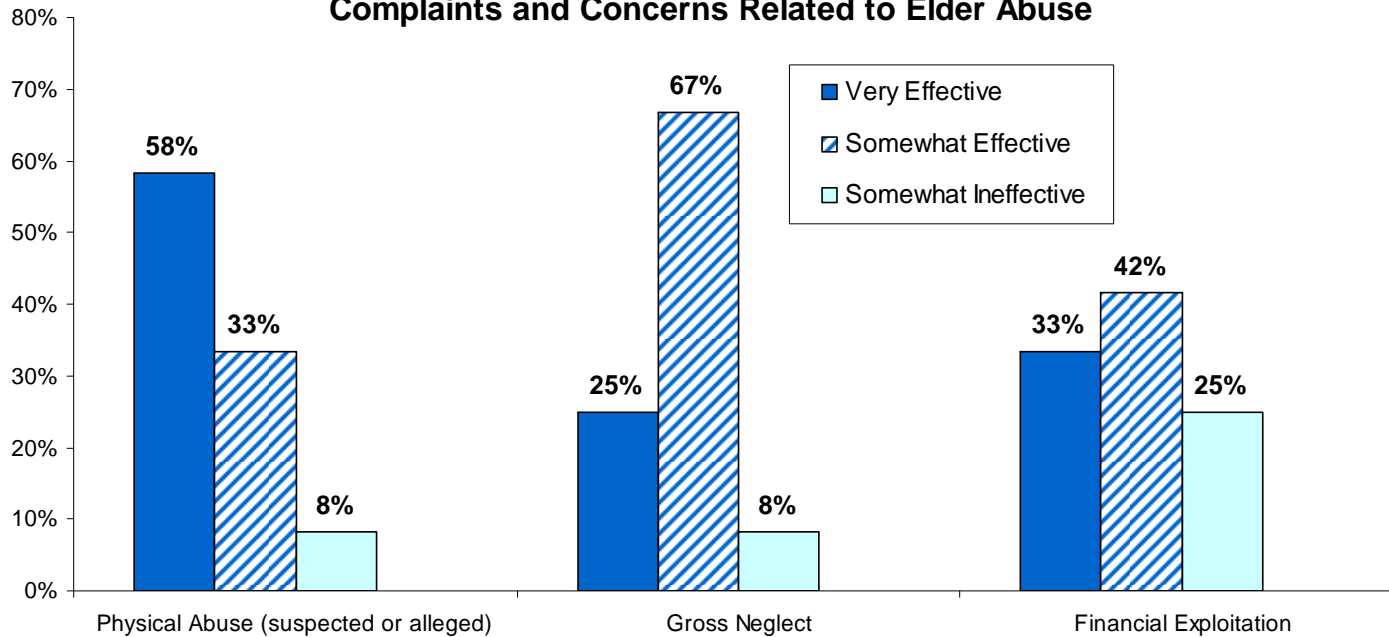
Q. For each of the following, tell us how you would rate specific content areas of the training provided to staff (paid & unpaid staff) of your LTCOP?

For most specific content areas, program coordinators rate training provided to paid and unpaid staff as average or above. Complaint investigation in nursing homes, investigating abuse and neglect, dealing with confidentiality and privacy, and addressing laws, policies and rules receive the highest (100%) ratings. Two areas which receive the lowest percentage of satisfactory ratings include system advocacy (42%) and mental health issues (58%).

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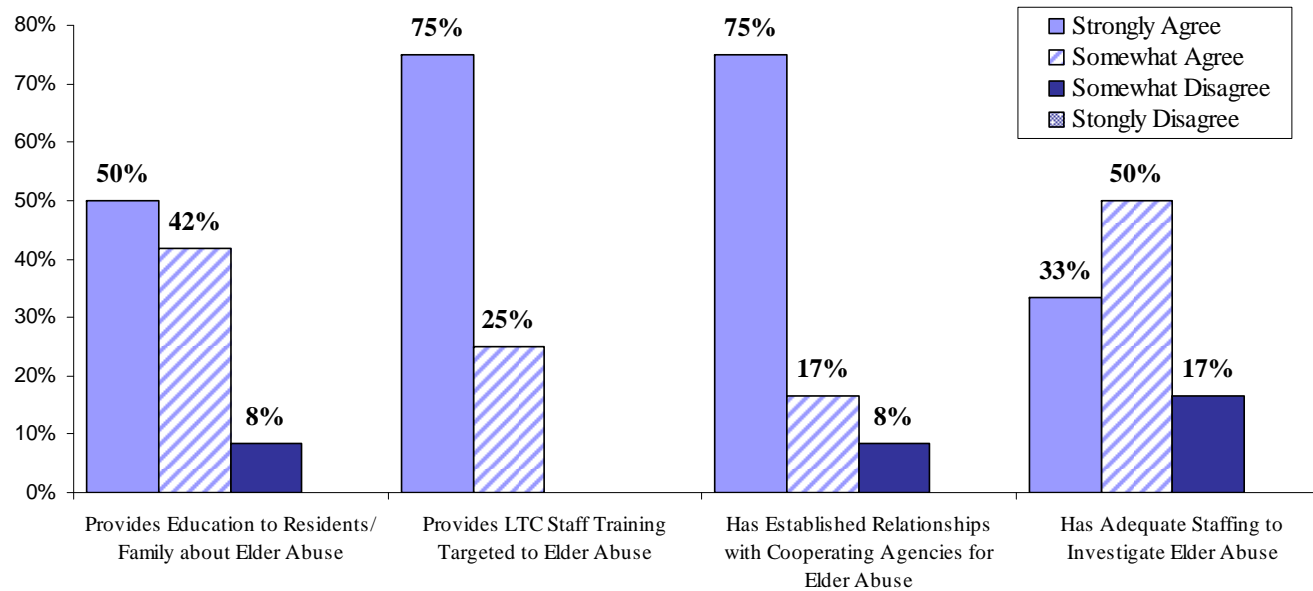
Figure 4.1: Self-Rated Effectiveness of Regional LTCOPs in Addressing Complaints and Concerns Related to Elder Abuse



Q. How would you rate the effectiveness of your local LTCOP in addressing complaints and concerns related to ...?

In general, program coordinators rate program efforts in handling complaints and concerns related to physical abuse (91%), gross neglect (92%), and financial exploitation (75%) as either very or somewhat effective; 25% (N = 3/12) rate their handling of financial exploitation as somewhat ineffective.

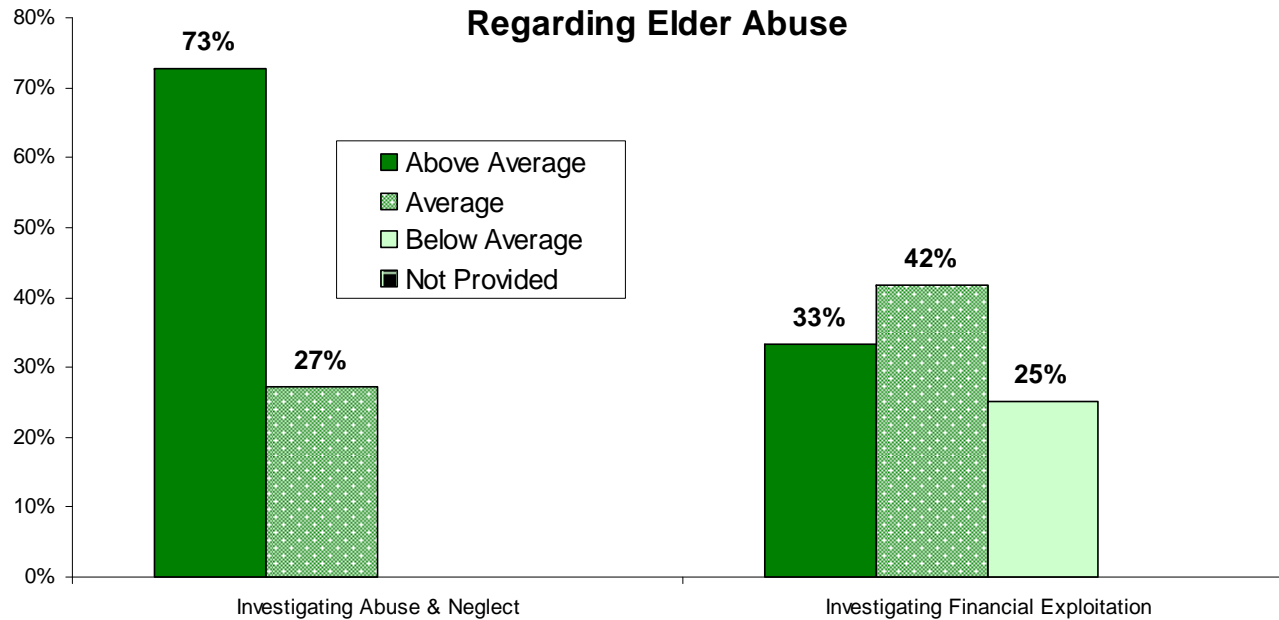
Figure 4.2: Extent to Which Characteristics/ Activities Apply to Regional LTCOPs in Issues Related to Elder Abuse



Q. for each of the following indicate whether you 'strongly agree,' 'somewhat agree,' 'somewhat disagree,' or 'strongly disagree' that the item applies to your LTCOP.

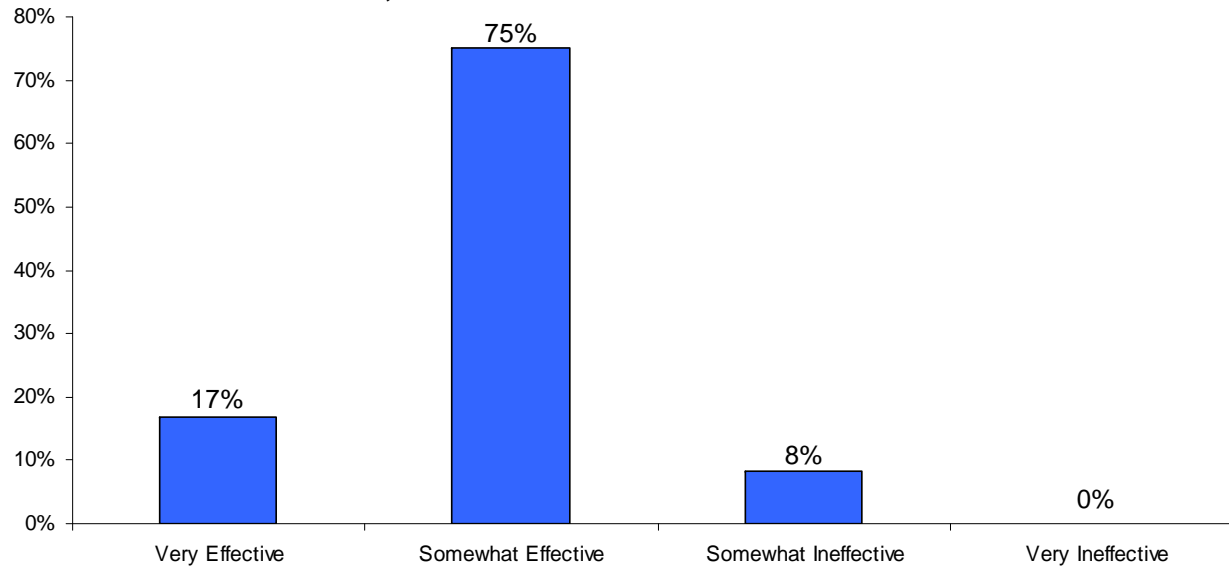
Generally, program coordinators agree (strongly or somewhat) that the LTCOP provides specific education to residents and families about abuse, neglect and financial exploitation (92%), provides LTC facility staff training in these areas (100%), has established cooperative relationships with other agencies to help investigate complaints (92%), and has adequate staffing to investigate (83%).

Figure 4.3: Ratings for Training of Program Staff of Regional LTCOPs Regarding Elder Abuse



Q. For each of the following, tell us how you would rate specific content areas of the training provided to the staff (paid & unpaid) of your LTCOP? Program coordinators are more than twice as likely to rate training for staff regarding investigating physical abuse and gross neglect as above average (73%, N = 8/11) as they were to rate training for investigating financial exploitation in the same manner (33%, N = 4/12); 25% rate training for investigating financial exploitation as below average.

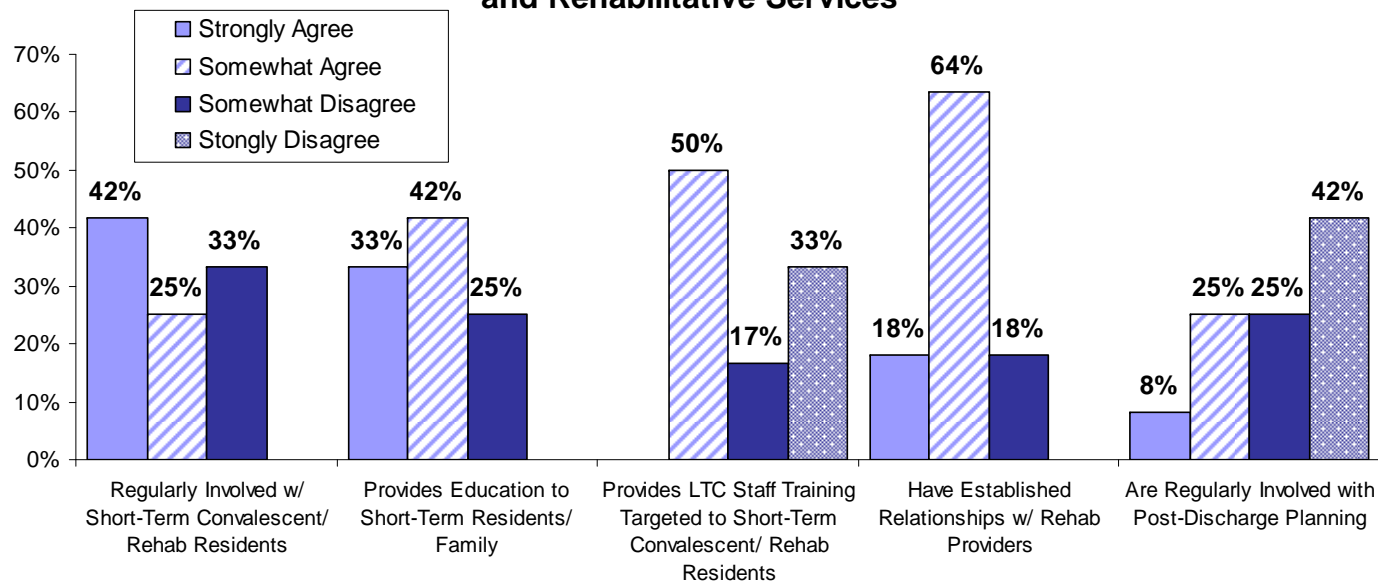
Figure 4.4: Self-Rated Effectiveness of Regional LTCOPs in Addressing Resident Needs Related to "Short-Term," Post-Acute, Convalescent and Rehabilitative Services



Q. How would you rate the effectiveness of your local LTCOP in addressing resident needs related to 'short-term' post-acute, convalescent, or rehabilitative services? (A "short-term" resident includes one whose stay in a LTC facility is expected to last less than 100 days or within Medicare coverage.)

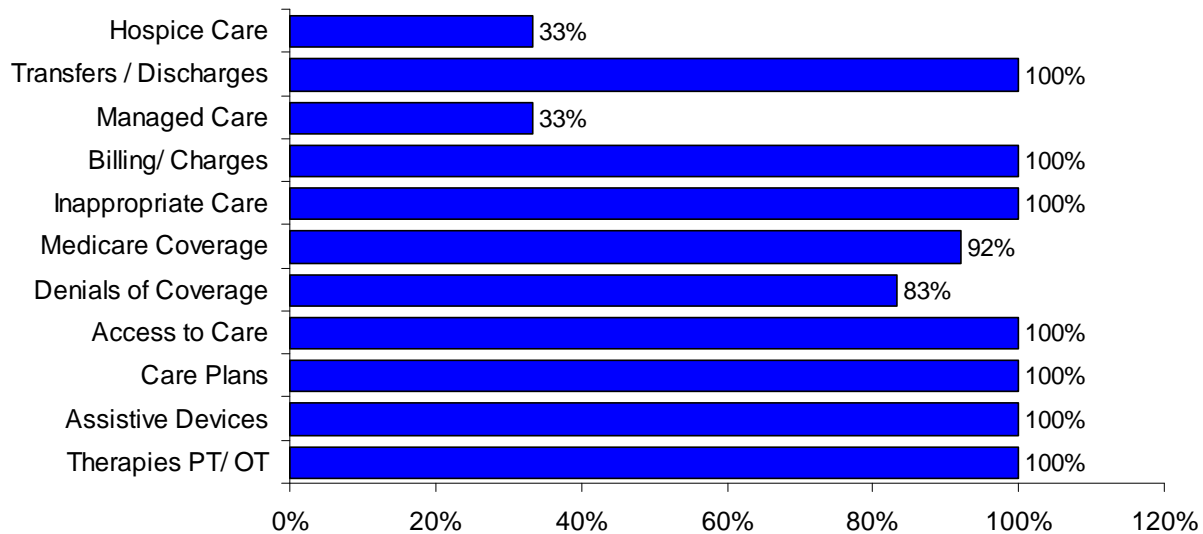
Three-of-four (75%) coordinators rate the program's addressing short-term resident needs as somewhat effective.

Figure 4.5: Extent to Which Characteristics/ Activities of Regional LTCOPs Apply to Post-Acute, Convalescent and Rehabilitative Services



Although LTCOP coordinators generally have established relationships with rehabilitation service providers (82%), and most programs are regularly involved with short-term convalescent or rehab residents (67%) and/or provide education to these residents and their families (75%), 50% do not provide targeted staff training aimed toward these residents and 67% are not regularly involved in post-discharge planning.

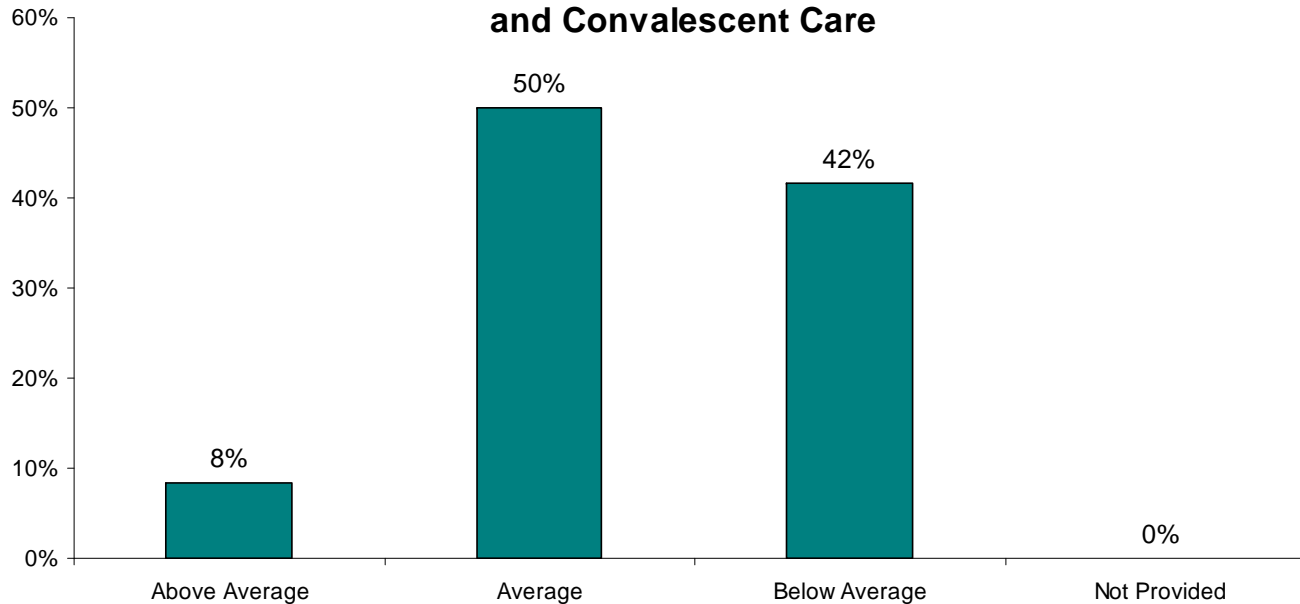
Figure 4.6: Regional LTCOP Involvement in Issues Related to Post-Acute, Convalescent and Rehabilitative Services in the Past Year (percent who responded "yes")



Q. Over the past year, have issues related to post-acute, convalescent, or rehabilitative service for residents addressed by your local LTCOP involved any of the following general issues?

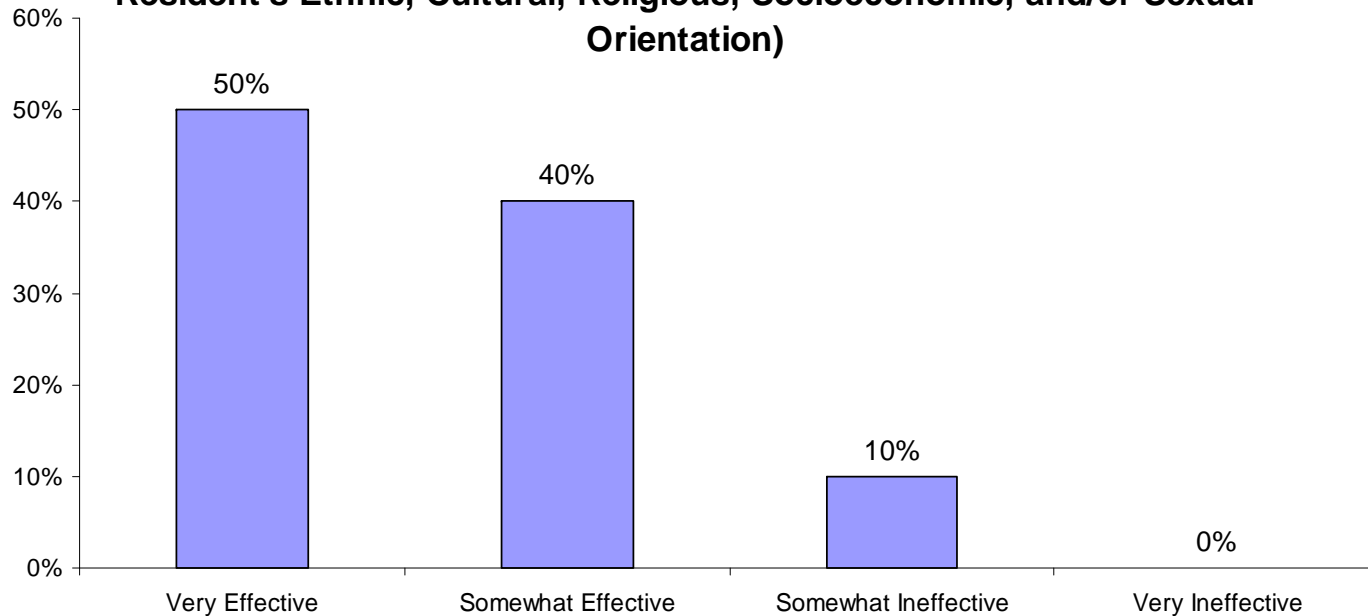
Regional LTCOPs are generally involved in a host of issues regarding post-acute, convalescent and/or rehab services for residents of various facilities. They appear least involved in managed care (33%) and/or hospice care (33%) for post-acute residents.

**Figure 4.7: Ratings of Training of Program Staff of Regional LTCOPs
Related to Post-Acute, Rehabilitative
and Convalescent Care**



Q. For each of the following, tell us how you would rate specific content areas of the training provided to the staff (paid & unpaid) of your LTCOP? Although 58% of coordinators rate training of program staff for addressing issues of post-acute and rehabilitative services as average or above average, 42% evaluate training in this content area as below average.

Figure 4.8: Self-Rated Effectiveness of Regional LTCOPs in Addressing Complaints and Concerns Related to Cultural Competence (Dealing with Resident's Ethnic, Cultural, Religious, Socioeconomic, and/or Sexual Orientation)

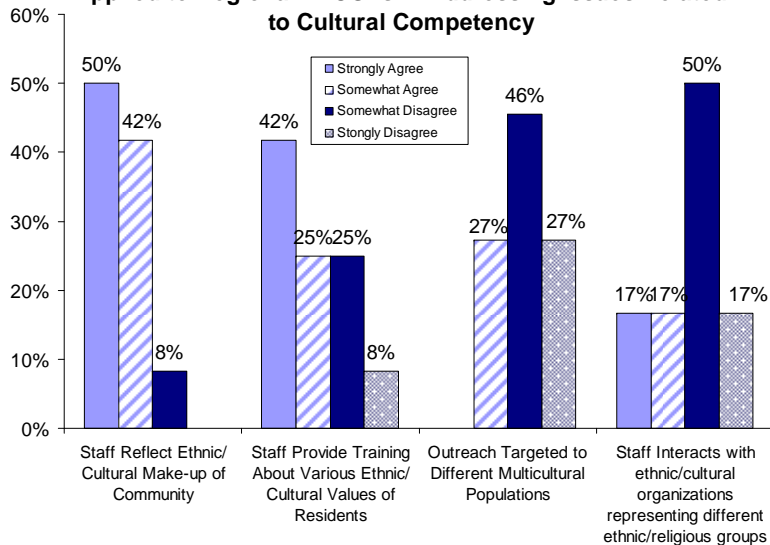


Q. How would you rate the effectiveness of your local LTCOP in addressing complaints and concerns related to resident's ethnic, cultural, religious, socioeconomic, and/or sexual orientation factors?

Whereas 90% (N = 9/10) of program coordinators, representing all 12 programs, rated their regional LTCOP's cultural competence as somewhat or very effective, one coordinator (10%) rated the LTCOP's efforts at cultural competence as somewhat ineffective.

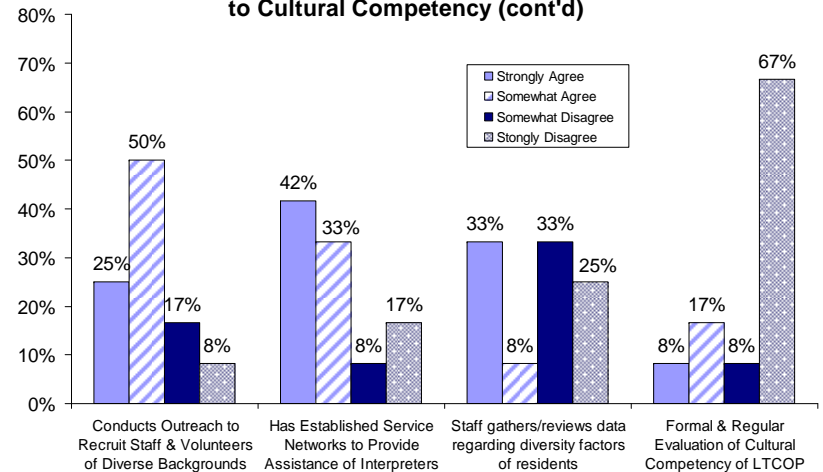
Cultural Competency

Figure 4.9a: Extent to Which Characteristics/Activities Applied to Regional LTCOPs in Addressing Issues Related to Cultural Competency



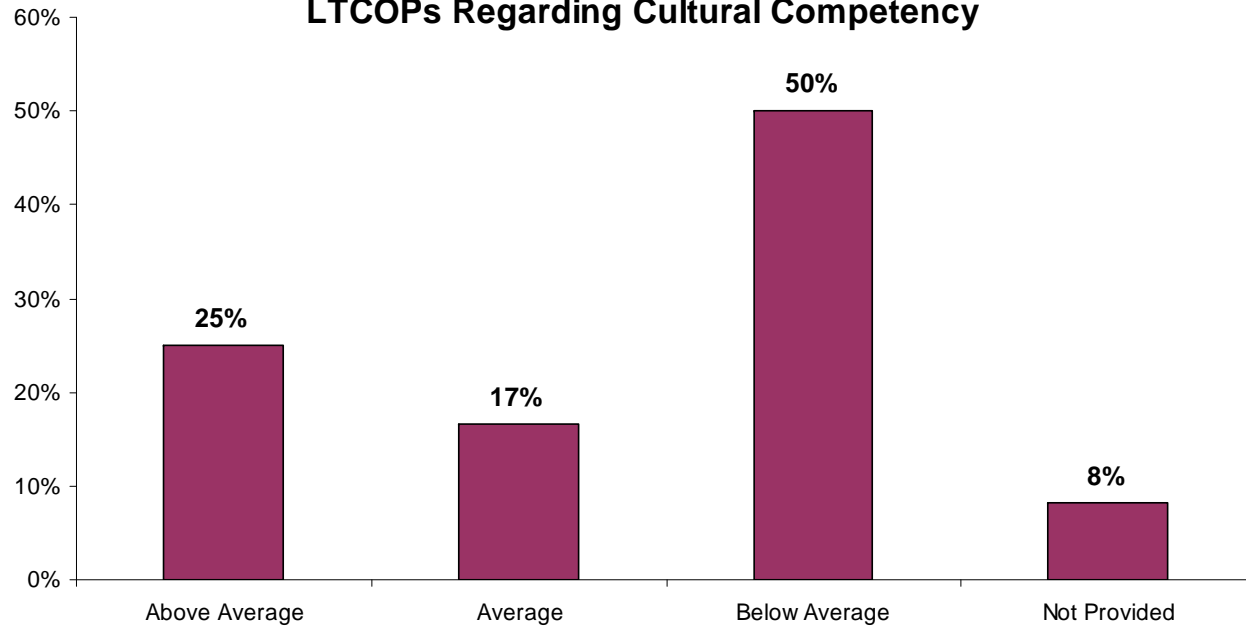
Q. For each of the following indicate whether you agree or disagree that the item applies to your local LTCOP. Ombudsmen vary in assessments of the LTCOP on issues of cultural competency. For example, whereas 92% (N = 11/12) agree that program staff reflect the ethnic and cultural make-up of the community and 67% (N = 8/12) agree that staff are provided some training about resident ethnic/cultural diversity, 73% (N = 8/11) suggest that the local LTCOP does not engage in educational outreach to different multicultural populations and 67% (N = 8/12) indicate that the program does not interact with organizations representing different multicultural and religious groups.

Figure 4.9b: Extent to Which Characteristics/Activities Applied to Regional LTCOPs in Addressing Issues Related to Cultural Competency (cont'd)



Q. For each of the following indicate whether you agree or disagree that the item applies to your local LTCOP. Most ombudsmen agree (75%, N = 9/12) that the local LTCOP does outreach to recruit staff from diverse ethnic backgrounds and the local LTCOP has established service networks to provide the assistance of interpreters, as needed. On the other hand, 58% (N = 7/12) indicate that the local LTCOP does not gather or review data on the diversity factors among residents served and 75% indicate that the local LTCOP does not do regular and/or formal evaluation of its own cultural competency.

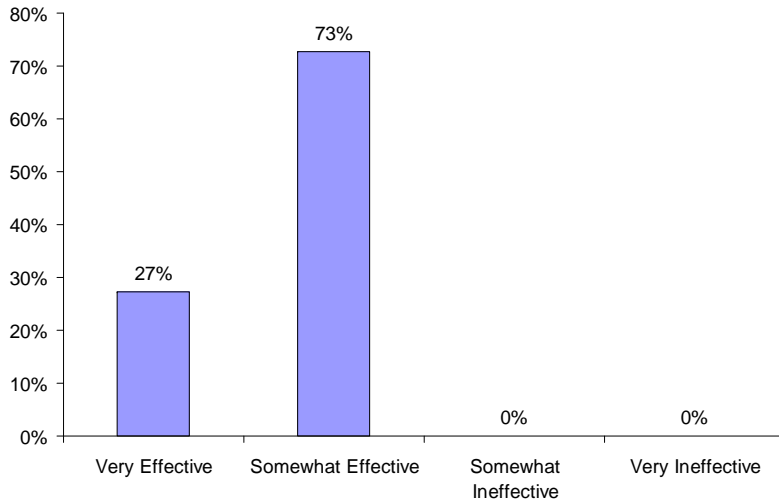
Figure 4.10: Ratings for Training of Program Staff of Regional LTCOPs Regarding Cultural Competency



Q. For each of the following, tell us how you would rate specific content areas of the training provided to the staff (paid & unpaid) of your LTCOP? Most ombudsmen (58%, N = 7/12) are dissatisfied with the training of program staff regarding cultural competency and rate this training as below average or not provided at all.

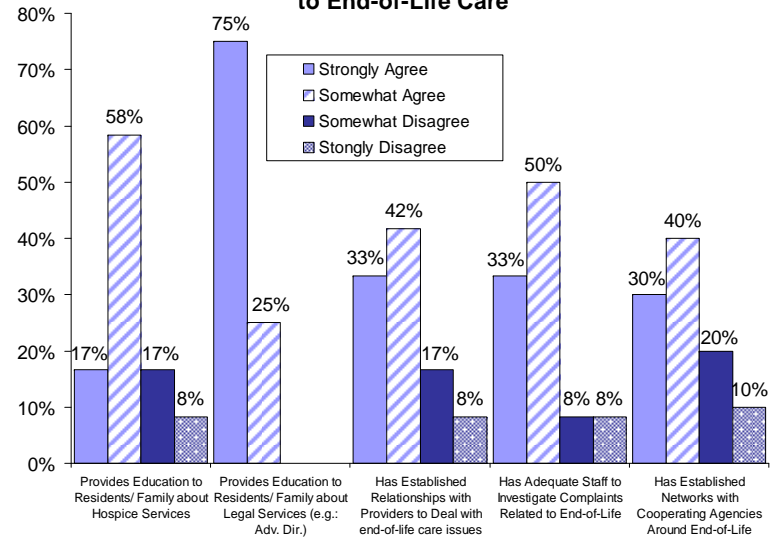
End-of-Life Care

Figure 4.11: Self-Rated Effectiveness of Regional LTCOPs in Addressing Complaints and Concerns Related to End-of-Life Care



Q. How would you rate the effectiveness of your local LTCOP in addressing complaints and concerns related to end-of-life care issues?
 In general, ombudsmen rate the regional LTCOPs as being very (27%) or somewhat effective (73%) in addressing issues that arise related to end-of-life care.

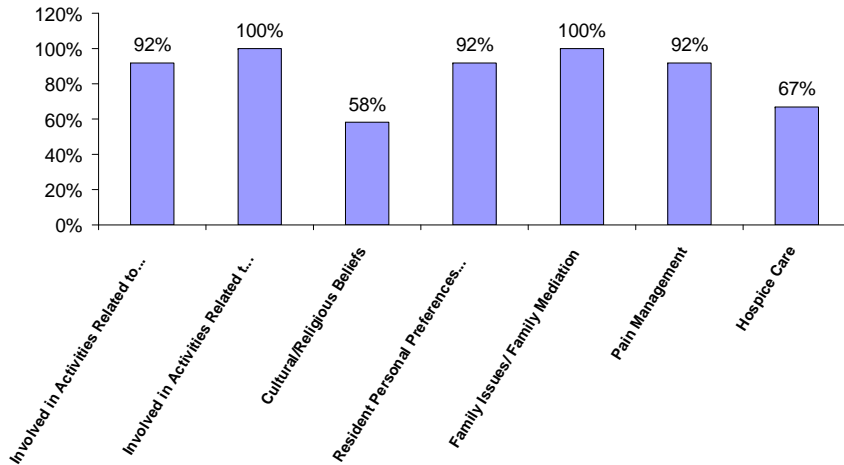
Figure 4.12: Extent to Which Characteristics/Activities Applied to Regional LTCOPs in Addressing Issues Related to End-of-Life Care



Q. For each of the following indicate whether you agree or disagree that the item applies to your local LTCOP.
 A majority of the ombudsmen generally agree (strongly or somewhat) that the regional LTCOPs engage in positive activities related to end-of-life care; 75% agree that they provide education about hospice services, 100% provide education about legal services, 75% have positive relationships with providers, 83% have adequate staff to investigate complaints related to end-of-life issues, and 70% have established relationships with cooperating agencies.

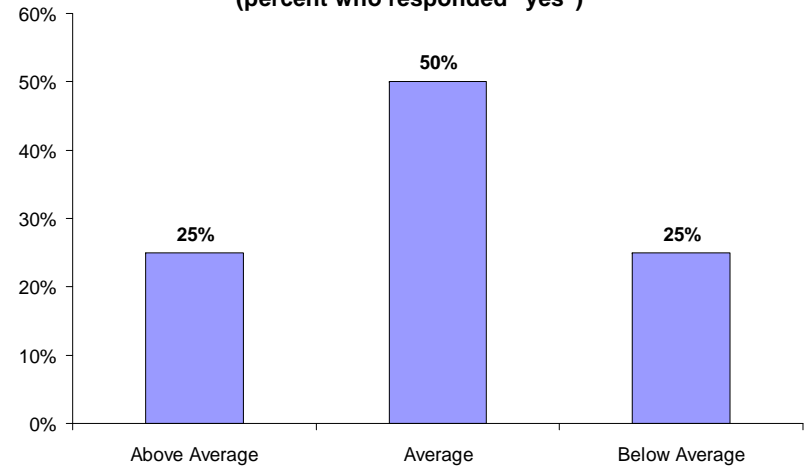
End-of-Life Care, cont'd

Figure 4.13: Regional LTCOPs Involvement in Issues Related to End-of-Life Care Over the Past Year (percent who responded "yes")



Q. Over the past year, have cases related to end-of-life care service for residents involved any of the following issues? Generally, the regional LTCOPs (> 90%) are involved in a wide array of issues related to end-of-life care. These include advance directives, legal orders, family issues and mediation, and pain management. "Only" 58% of the ombudsmen report that the regional LTCOP was involved in cultural/religious beliefs and wishes related to end-of-life in the past year; 67% reported dealing with hospice care issues in the past year.

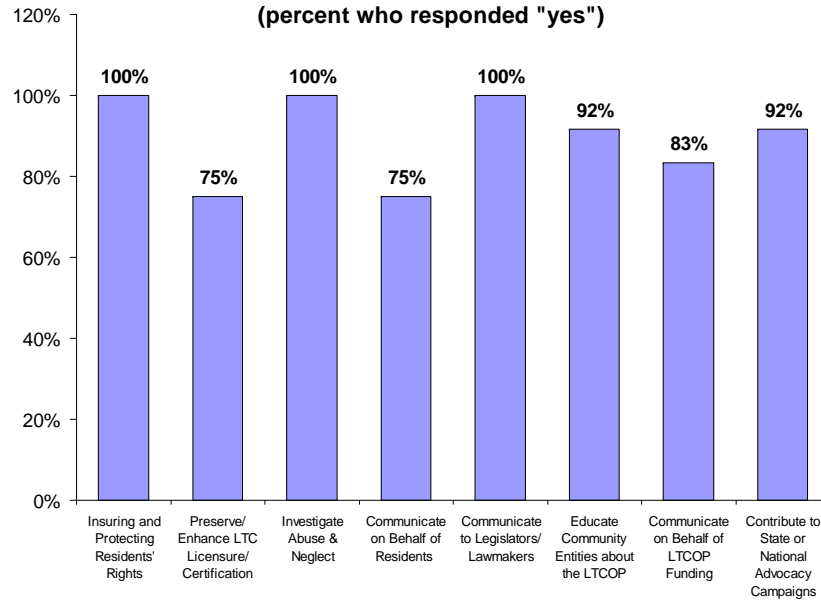
Figure 4.14: Ratings of Training of Program Staff of Regional LTCOPs in Areas Related to End-of-Life Care (percent who responded "yes")



Q. For each of the following, tell us how you would rate specific content areas of the training provided to the staff (paid & unpaid) of your LTCOP? Although 25% (N = 3/12) of the ombudsmen rate their staff training for dealing with end-of-life issues as "above average," an equal proportion rate this training as "below average."

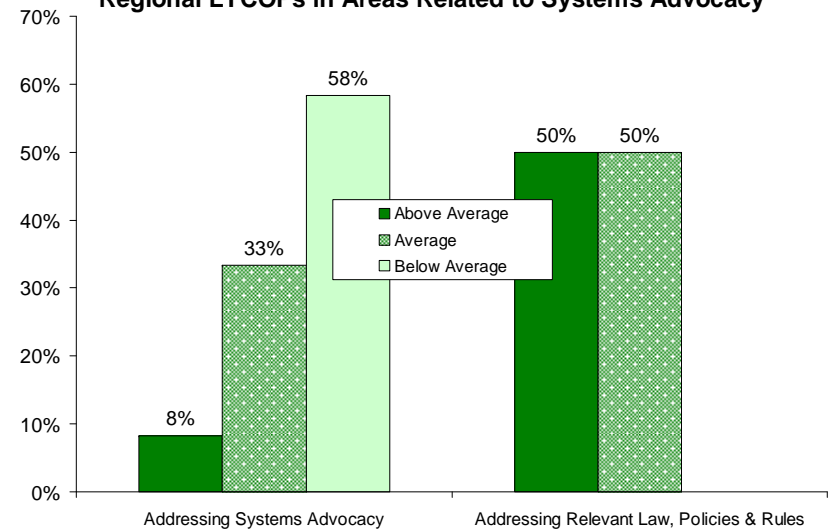
Systems Advocacy

Figure 4.15: Regional LTCOPs Involvement in Issues Related to Systems Advocacy Over the Past Year (percent who responded "yes")



Q. Please tell us if your local LTCOP engages in any of the following types of systems advocacy. The majority of ombudsmen (>75%) report that the regional LTCOP engages in a host of systems advocacy activities including insuring and protecting residents' rights (100%), addressing issues related to investigations of abuse and neglect (100%), and communicating on behalf of residents to legislators and lawmakers, among others (100%).

Figure 4.16: Ratings of Training of Program Staff or Regional LTCOPs in Areas Related to Systems Advocacy



Q. For each of the following, tell us how you would rate specific content areas of the training provided to the staff (paid & unpaid) of your LTCOP?

Whereas 100% of the ombudsmen rated staff training addressing relevant laws, policies and rules as average or above average, 58% rated program staff training on issues of systems advocacy as below average.

Legal Support & Services

Figure 4.17: Regional LTCOPs Access and Utilization of Legal Services and Support Over the Past Year (percent who responded "yes")

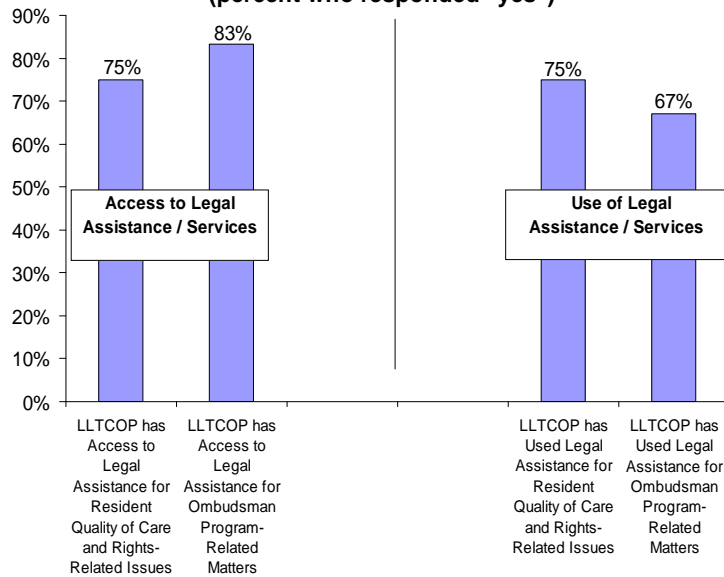
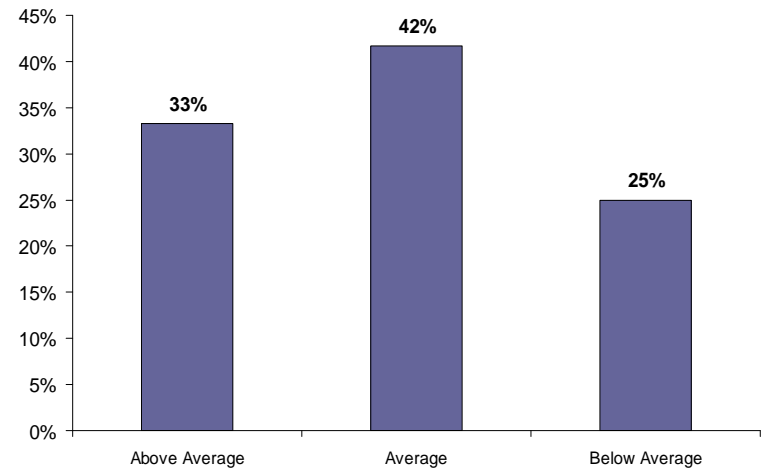


Figure 4.18: Ratings of Training of Program Staff of Regional LTCOPs in Areas Related to Identification of Potential Legal Issues



Q. For each of the following, tell us how you would rate specific content areas of the training provided to the staff (paid & unpaid) of your LTCOP?
 Three-of-four ombudsmen (75%) rate training for program staff on potential legal issues as average or above average, whereas 25% rate such staff training as below average.

Q. Does your local LTCOP have access to legal assistance for Resident Quality of Care and Rights (or Ombudsman Program) related matters? Has your local LTCOP used legal assistance for Resident Quality of Care and Rights (or Ombudsman Program) related issues in the past year? Whereas 75% of ombudsmen reported that the local LTCOP had access to legal services and used these legal services for resident quality of care and rights matters, 83% reported that the local LTCOP had access to legal services for Ombudsman Program matters and only 67% actually used these legal services.

Overview

Central to our research initiative is a commitment to informing and helping catalyze policy discourse and refinement, as Ohio faces population aging and systemic changes in the long-term care system. Local LTCO programs play a focal role in addressing the needs of care recipients. However, they do not play this role in isolation. Rather, they do so in concert with many other actors and agencies whose knowledge of, and perspectives toward the program shape its performance and effectiveness in myriad and consequential ways.

In this chapter we present information from the Informed Respondent Survey. We conducted in depth, open-ended and semi-structured interviews with ten (10) *Informed Respondents* (IRs) who have extensive knowledge of, and varied contacts with, the Long-Term Care Ombudsman Program (LTCOP) in Ohio. All of the interviews except one were conducted in-person, in the respondent's workplace or a neutral setting; one interview was conducted by telephone in order to accommodate the informant's schedule. Interviews ranged in duration from 45 to roughly 100 minutes, and were transcribed verbatim to document both open-ended responses and elaborations on survey items.

The purposive sample of informants was developed in a step-wise fashion: The researchers first developed a list of structural positions/roles which we determined to be important in the operation of the LTCOP. The initial list was defined both conceptually and experientially, as well as through consulting professional colleagues and policy literature on Ombudsman programs. We also reconciled our sampling choices with prior state-level case studies in New York and California.

Next, we elicited suggestions from Ohio LTCOP Directors and state-level LTCOP personnel regarding important positions/roles in the larger constellation of actors and agencies involved in ombudsman activities. We also sought suggestions regarding specific informants who, by reputation and/or experience, offered valuable knowledge and perspectives bearing on research questions. We finalized a list of informants who represent both varied and important roles in conjunction with the LTCOP, and who figure to be important stakeholders in future policy discourse and action in connection with the protection of LTC recipients. This final list includes those from a range of academic, legal, policy, administrative, governmental, and trade associations. We also sought out those with experience in the urban northeast section of the state, where issues of cultural and ethnic diversity are especially salient.

Informed Respondents:

1. *Certified volunteer ombudsman—Level II*
2. *Volunteer coordinator for a large regional LTCOP*
3. *Director of Area Agency on Aging in large Urban PSA*
4. *Representative of Ohio Department of Health*
5. *Director of Ohio community-based care advocacy association*
6. *Representative of large non-profit provider network*
7. *Policy analyst/expert from the Ohio Department of Aging*
8. *Director of LTC provider association*
9. *Legal services/probate court specialist*
10. *Director of a non-profit, non-sectarian health and social service agency*

To facilitate comparison across the entire study, protocols for the Informed Respondent (IR) interviews were similar to those of the LTCOP survey. The survey instrument consisted of many modules from the Program Director survey, including questions regarding informants' backgrounds; general perceptions; degree of familiarity with ombudsman programs and policies; views of autonomy and program performance; training and professionalization; elder abuse, neglect, and financial exploitation; rehabilitative, convalescent, and post-acute care; cultural competency; end-of-life care; legal services and support; systems advocacy; and summing up. Although we develop comparisons between IRs and LTCOP Directors, based on our survey data, we also stressed a more open-ended, inductive inquiry through which IRs could define and develop particular issues and domains of interest that were not defined beforehand.

Even assuming the LTC system to be in a “steady state,” centering on nursing home care, one nonetheless needs to consider and understand the collaborative, interdependent relations that are essential for LTCOPs to operate effectively. As we were often reminded during our interviews, the LTCOP is a *complaint-driven* system. Also, it is a program that relies, to the greatest extent possible, on trust, good-will, and the flow of information as opposed to accusations or confrontation between LTCOP staff and care providers. Many of the problems that can plague the quality of long-term care are systemic, rather than the result of overt intention or neglect. For example, staffing shortages and high staff turnover (which approaches 100% annually in some facilities) are endemic in long-term care settings nationally, and such conditions clearly expose residents to risks: injuries to residents during transport, for example, may be rooted in staff inexperience, or simply in a shortage of staff at critical moments. Consequently, seeking to prove negligence or the intent to injure is both extremely difficult and ultimately corrosive of the good working relationship that LTCOP staff, volunteers, and care-providers seek to preserve. Finding mechanisms in the larger interdependent network surrounding the LTCOP that enhance quality of care and oversight for residents is a key objective of including informed respondents in this study.

However, the LTC system in Ohio is far from static. In fact, it is in the midst of a fundamental shift toward greater reliance on home and community-based services. As we argued earlier, in analyzing the Program Director data, this systemic shift we regard as a crucial backdrop for interpreting current and future strains in the effectiveness of Ohio's LTCOP. Specifically, the formal regulations governing quality of care (and resident rights) vary across settings, as do the awareness of the LTCOP and cultural expectations residents have regarding care and rights. For example, the LTCOP is heavily reliant upon volunteers, who are the "eyes and ears" of the program in particular care settings. Also, because they lack formal enforcement power, LTCOPs must operate under conditions of mutual respect and accommodation with care providers and agents of the Ohio Department of Health, whether in quasi-medical settings such as nursing homes and clinics, or in the growing number of alternative/non-medical institutional settings such as residential care or assisted living.

In addition, the training and expertise required of certified volunteer LTCOs need to be re-evaluated in light of systemic changes within Ohio's LTC system. In fact, several implications of systemic change in Ohio's LTC system can be seen through the lens of the volunteer role. As one respondent, with nearly twenty years' experience with the program explained, "Many people we see today in nursing homes would, in the past, have likely been treated in the hospital; but we discharge them sooner now, to nursing and rehab[ilitation] facilities. In turn, many residents today in assisted living would in the past have been expected to reside in nursing homes; thus, the acuity or severity of residents' health problems has become more serious across the continuum of care." In practical terms, this shift, toward "post-acute and rehabilitative care" in nursing homes means that volunteers in these settings are being asked to oversee patients whose treatment may be short in duration and require elaborate technical or medical support. Without orientation to issues—such as side-effects of chemotherapy or radiation, maintaining patients who are tube-fed, or monitoring the adequacy of physical or occupational therapy following a stroke—even the most conscientious volunteer could be ill-prepared to carry out their oversight and advocacy roles.

Moreover, the role of volunteer LTCOs in the growing domains of non-nursing home institutional settings and home and community-based care are changing, both in overt and more subtle ways. First, resident rights in residential care facilities are, in principle, the same as in nursing homes. However, as a practical matter there is likely to be more desire for flexibility—among residents and staff alike—in residential care. And in the case of small, independently-run "adult care" homes, there may not be resources to maintain the physical environment (e.g., general upkeep, new furniture) that one would ideally desire. Second, residential and adult care homes promote a greater sense of privacy and autonomy than is generally possible in nursing homes.

This cultural norm creates ambiguity, if not real discomfort, for those such as LTCOP volunteers, seeking to enter such quasi-domestic settings in order to investigate or resolve residents' complaints.

Such regulatory and cultural nuances are compounded by the sheer geographic dispersion of residential and adult care settings, all of which account for the marginal presence in them of LTCOP staff. Those informed respondents who addressed this issue directly suggest that a) current staffing patterns and volunteer training need to be re-assessed in the context of the move toward residential care; and b) it is especially important in such settings that LTCOP staff take a conciliatory, rather than adversarial, stance in discussing and resolving complaints.

People receiving home health services and/or care through such Medicaid waiver programs as "Choices" also qualify for oversight through the LTCOP. However, most people continue to associate the LTCOP only with *nursing home care* and so are consequently unlikely to call on the program, even in the presence of serious concerns about quality of care. This inter-related set of issues illustrates that the formal lodging and resolution of complaints is, in the broad scheme of things, a relatively small part of a process in which *informal communication and mediation* play major roles.

Informed respondents were asked to describe “in their own words” what they consider to be the mission of the LTCOP

To strongly advocate for those concerns that affect long-term care consumers both in facilities and in the community, whether through local advocacy or systemic advocacy. It's doing what's right for the person, regardless of their disabilities or life circumstances. –Volunteer Coordinator

I would say the mission of the regional LTC ombudsman program is to provide advocacy, counseling and support to consumers of LTC services particularly individuals in nursing facilities. –Administrator of LTC Setting

I believe their goal is to be advocates for their residents. –Health Department Official

I think they have multiple goals, but the primary goal is to investigate and resolve conflicts between consumers and providers of long-term care services with a bias, and an acknowledged bias, towards the protection of the consumers. The presumption is that the consumer is at a disadvantage in their relationship with the provider, and I think properly so. But [the mission] is not perceived that way by all concerned. There is an obligation for the LTCO to be objective in their analysis, because you're not helping their consumer by giving them a reason to think that they ought to be unhappy when there's really not a reason. –Policy and Research Specialist

It is to be the voice of the consumer in long-term services and supports. Clearly their heaviest focus is still on institutional long-term care. But in Ohio we were one of the early adapters to the model that holds the ombudsman should have some role for consumers in community-based long-term services and supports as well, and Ohio's law requires that. But anyway it really is being the voice of the consumer and a specific role in handling and resolving complaints from consumers and some other things too, but the essence, the heart of it is the ability to successfully negotiate complaint resolution for consumers. –Legal Specialist/Advocate

I think the first one is to enforce the health and safety of long-term care facility residents. The second thing is to advocate and mediate both with long-term care staff, home providers, you know for the contacts they have that are in the community. So it would be health and safety and advocacy. –Non-Profit Sector Advocate

Informed respondents were asked to describe what they consider to be “key issues” for LTCOPs in nursing homes

Among the most numerous are food and treatment. But, when you say key, I'd say treatment. I don't mean medical treatment, per se, but conflict or perceived conflict between individual staff members and residents. That has a huge bearing on the quality or the experience that the resident has. In some ways it is as important as the medical treatment itself.

Another aspect of treatment goes to the family's expectations. Families really are very anxious and want what they see as being the best for mom or dad. Long-term care is more complicated than people think. And there are sometimes very subtle and difficult treatment decisions being made. And the physicians are not always on their toes. Treatment issues are also related to patient transfers to hospitals and back. In that welter of events, the ombudsman may have a real hard time picking apart who did what to whom. But try we must.

--Policy Specialist and LTC Administrator

From a nursing home perspective I think they would view effectiveness as being an ombudsman who doesn't really get in their way a lot, doesn't create a lot of problems for them, but that can help resolve complaints that are mutual problems where family and nursing home aren't communicating well, But that's probably not the definition of effectiveness that would come from the people who are paying you to do this study. They would want to know, "Are the LTCOs in there, you know, busting those complaints and really being aggressive?" But my members wouldn't view that as effective. They would view that as a pain in the butt.

--Director of LTC Trade Association

Accidents of unknown origin. Somebody falls. They can't figure out why. Somebody slides off the end of their bed. There's a bruise that's noticeable the next day, by a family member or a nurse, and they want answers. Of course, it's not always an abusive situation. More often it has to do with staffing: there's supposed to be two person lift but there aren't enough people there. Some residents are supposed to have attention at all times, and the aide will go out in the hall to get something, to help clean them up or something. That can be a critical moment. Not that the injury is any the less serious, but I don't think it's always or frequently done with the intent of causing harm.

--Volunteer Coordinator/LTCOP Program Developer

I've had many cases of nursing home eviction, usually over payment issues. Also, I've dealt with cases that really were over the behavior of the nursing home resident. Often the root of the question is whether they (nursing home staff) are using the least restrictive alternatives in their care for the person. Are they exploring ways to redirect the problematic behavior—say with a dementia patient—or trying to address the problem that is causing the resident to act out? The ombudsman's role is advocacy and enforcing rights for residents. But, clearly, carrying that out touches on many complex issues.

--Legal Specialist

Informed respondents describe what they consider to be challenges for the LTCOP in residential care settings

*Note that I.R. s sometimes use “residential” and “board and care” interchangeably; board and care is not a commonly used term in Ohio.

*Even badly run nursing homes get to know how to provide what the ombudsman is going to be looking for. So there’s a lot of documentation, a lot of paper. And as hard as [complaints] can be to sort out, there’s a fair amount of evidence sitting around if you know how to use it. In residential and board & care facilities—as you go down the chain—there’s less paper and documentation around. So I would think that the LTCOP investigations are harder to make, given that there may be less tangible evidence –**Policy Specialist and LTC Administrator***

*In board & care just insuring their residents get basic services is, I think, the really critical thing; with a small staff and limited resources, there’s a small margin of error. Beyond that, the issue is what kind of life do the residents of board & care facilities have. Too often they just sit there all day, lacking much of any stimulation or socialization. –**Former Program Director, and State Policy Specialist***

*Many community settings are less regulated in Ohio. And their residents often have less family support. A key element in the LTC ombudsman role is having family involved to complain and seek help. Particularly in adult care facilities, individuals have social circumstances that probably mean weaker family and social support systems. –**Director of Area Agency on Aging***

*In small board & care homes, although residents’ physical needs are met, I think that the social aspects of care can be narrow or limited. That can be true, even though the whole idea of board & care facilities is to provide support so that the person can successfully meet their needs. In some ways they’re almost more restricted [than nursing homes], because the caretaker in a board & care facility simply doesn’t have the staff to take five residents out in the community; or, to supervise people at home, while they take other people on outings. I’ve seen the long-term care ombudsmen involved in this kind of advocacy. Just because a resident might be living in the community, that doesn’t necessarily mean it’s an improvement over a long-term care nursing facility. –**Legal/Policy Specialist***

*Where long-term care facilities rely on the ombudsman to help with patient and family education, there’s a set of expectations and a regular presence. Each resident [in a nursing home] will be informed of rights and told about the LTCOP. In smaller board & care facilities there are fewer visitors, fewer staff, and so fewer people going in to view whether or not there’s a concern that should be referred to the ombudsman. –**Legal and Policy Specialist***

Informed respondents described other issues which they see as having important implications for Ohio's LTCOP

I'm one of these people who thinks that the Ombudsman program should not be part of an Area Agency on Aging. That can mean conflicts of interest, particularly as AAAs have gotten more involved with in-home care and services. I definitely think it's a potential conflict of interest. On the other hand, an advantage of having LTCOP sponsorship by [religious agency] is that they have a philosophical commitment to each one of their programs. It's true to such a degree that they will do whatever's necessary to insure continuity, even during down times of funding. [Local LTCOP] has been able to grow in a way that few other parent organizations would have made possible.

–Program and Academic Specialist, discussing issues regarding where/how regional LTCOPs should be housed.

For some people in high positions in the LTCOP, the staffing concept of the program is, in effect, "I'll take these kids right out of college and pay them an entry level wage. I'm going to train them well and then they'll move on to their next job, so the LTCOP will be a training ground for careers in aging." Well, that doesn't ensure the best performance for the LTCOP. But on the other hand, it's true that experienced professionals would probably have to take a large salary cut to work for the state.

–Legal and Policy Specialist, discussing the challenge of recruiting and retaining effective LTCOP staff.

I question what their role is and what their role ought to be. They really have no formal authority to do anything, and that can be a good or bad thing depending on your perspective. All [LTCOs] have the authority to do is to go into facilities and look at stuff and talk to people, but in terms of enforcement, they have zero. So the best they can do is refer things to the health department. Some of them try to act like they have some kind of authority and badger the members and that's where we sometimes get complaints from our members. I suppose strong [LTCOP] supporters believe they ought to have some kind of ability to sanction nursing homes in some fashion. Our members obviously wouldn't support that kind of thing because we've already got plenty of people who can put sanctions on us. This goes to the central question of if these folks are really performing a useful service at all. –Representative of Provider Association, discussing the role and lack of formal enforcement power of LTCOPs

For physical abuse, gross neglect, there needs to be a lot more education done with law enforcement officials.

Unless the witness is really credible they may not investigate or they may say, "Oh, this person is really confused." That applies to many older people in LTC.

–Volunteer Coordinator, discussing abuse complaints and seeing cooperation with law enforcement.

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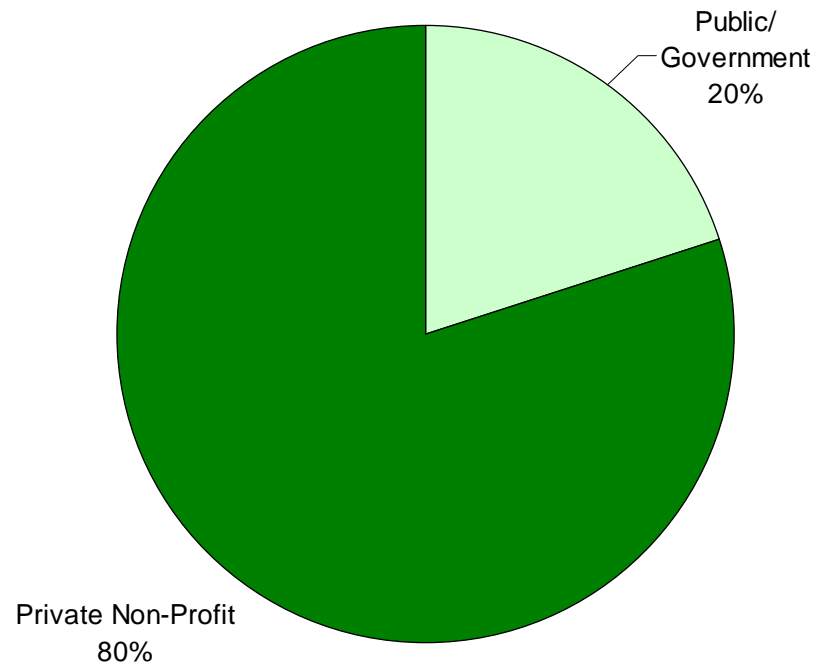
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Figure 5.1: Type of Agency in Which the Respondent Works



Self-Perception of Knowledge

Figure 5.2: "I am Knowledgeable About Local LTC Ombudsman Programs"

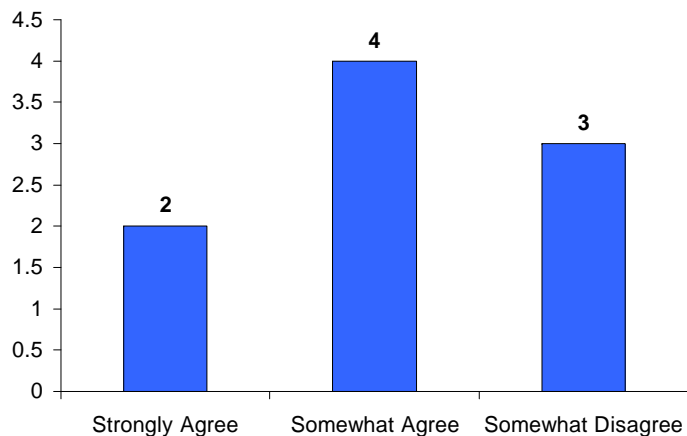
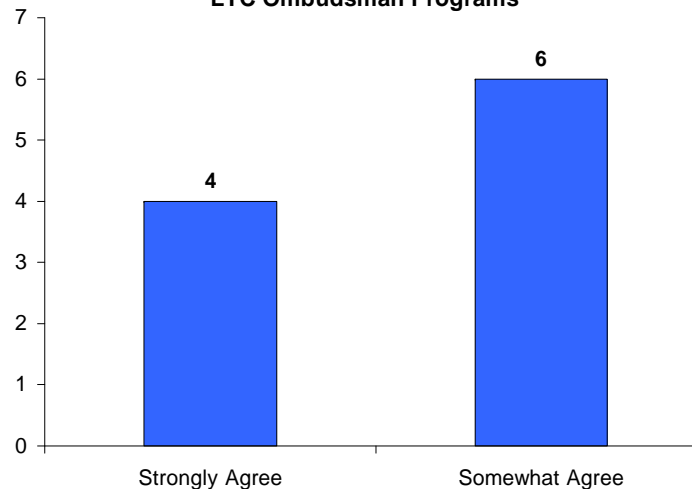
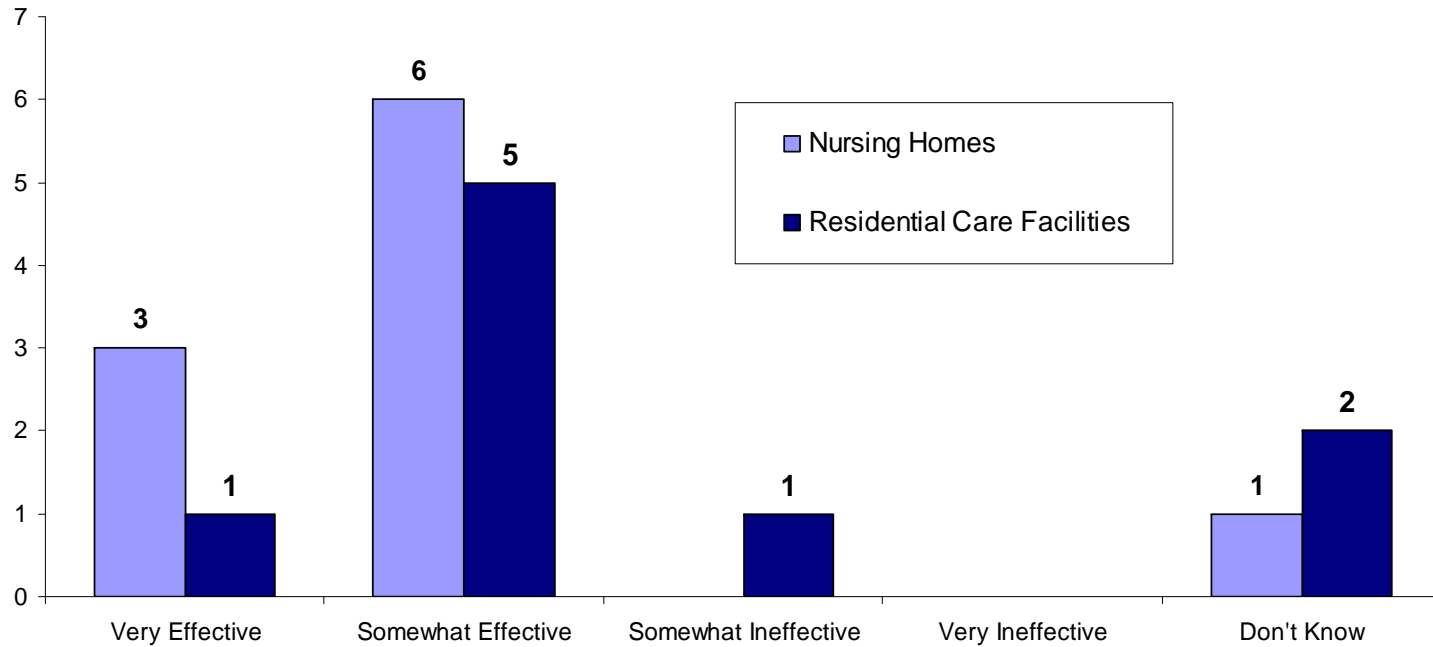


Figure 5.3: "I am Knowledgeable About LTC Ombudsman Programs"



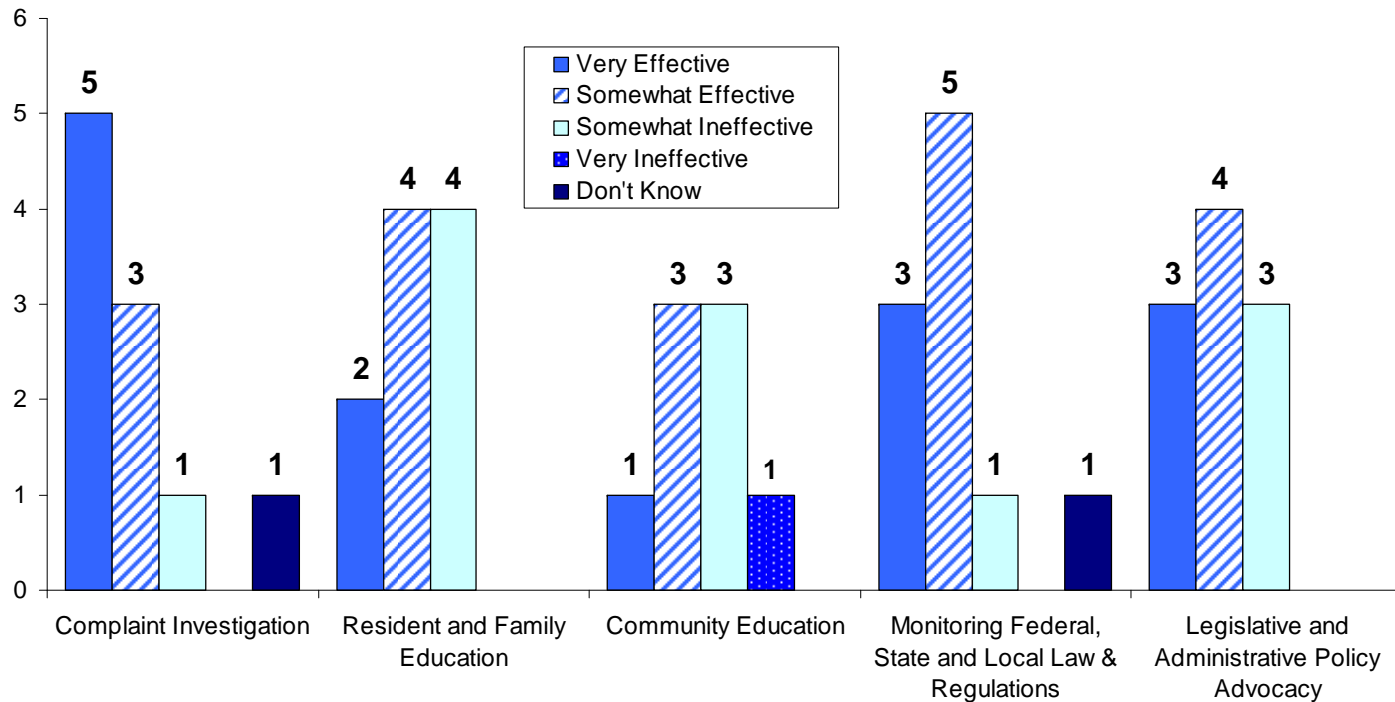
Note: One informed respondent did not answer this question.

Figure 5.4: Rate Performance of Local LTCOPs in Nursing Homes and in Residential Care Facilities



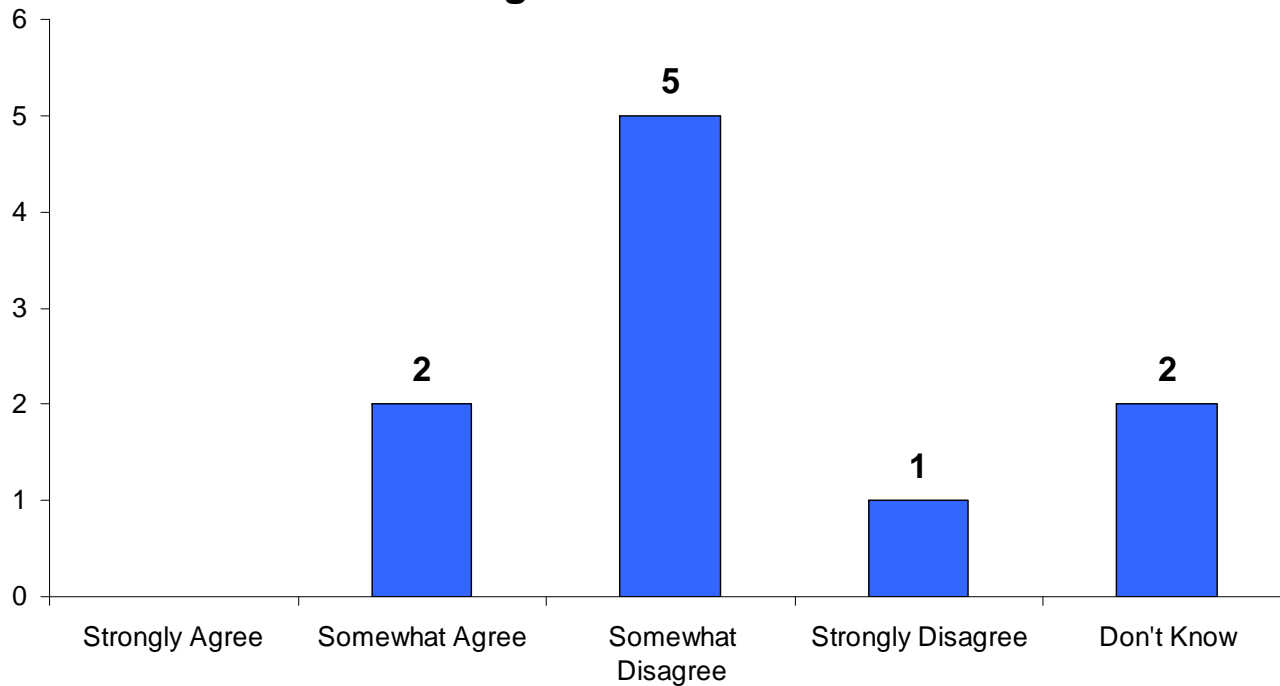
Note: No informed respondent chose the "Very Ineffective" response. One respondent did not answer the question regarding residential care facilities.

Figure 5.5: Rate Performance of Local LTCOPs



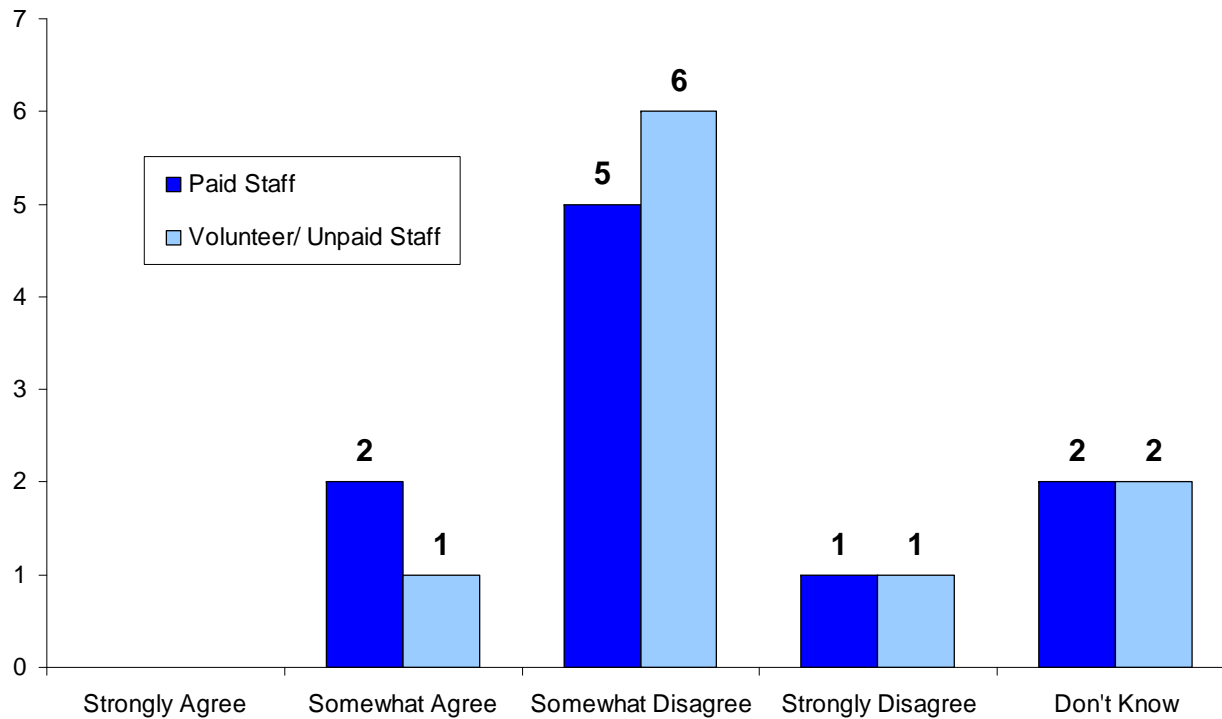
Note: Two informed respondents did not answer the “Community Education” component of this question.

Figure 5.6: Do Local LTCOPs Have Sufficient Funding to Perform Duties?



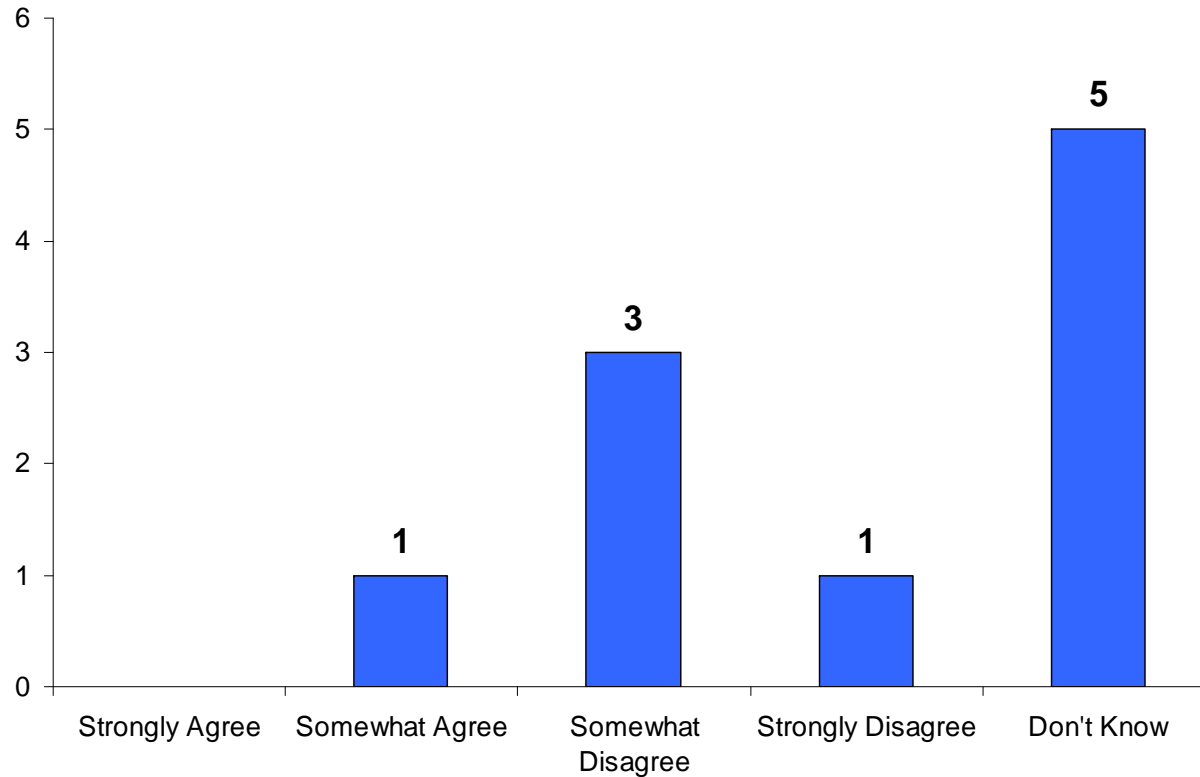
Note: No informed respondent chose the “Strongly Agree” response.

Figure 5.7: Do Local LTCOPs Have Sufficient Paid and Volunteer Staff to Perform Duties?



Note: No informed respondent chose the “Strongly Agree” response.

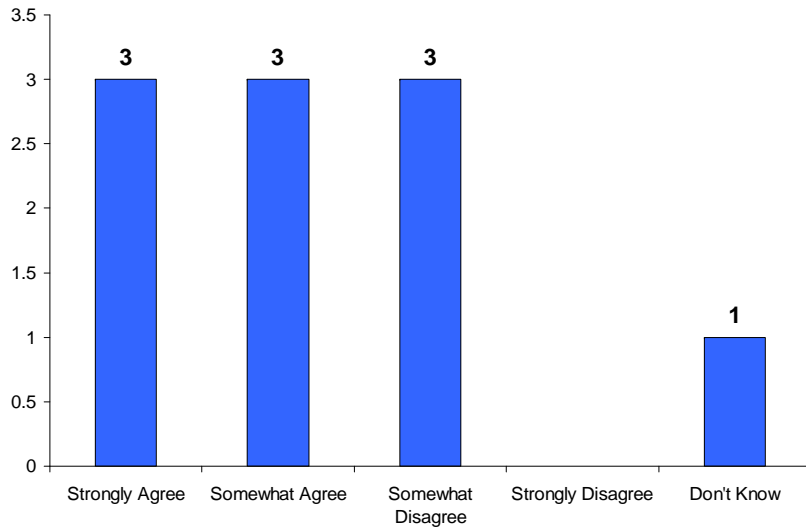
**Figure 5.8: Do Local LTCOP Coordinators/
Directors Receive Salary Equal to Duties?**



Note: No informed respondent chose the “Strongly Agree” response.

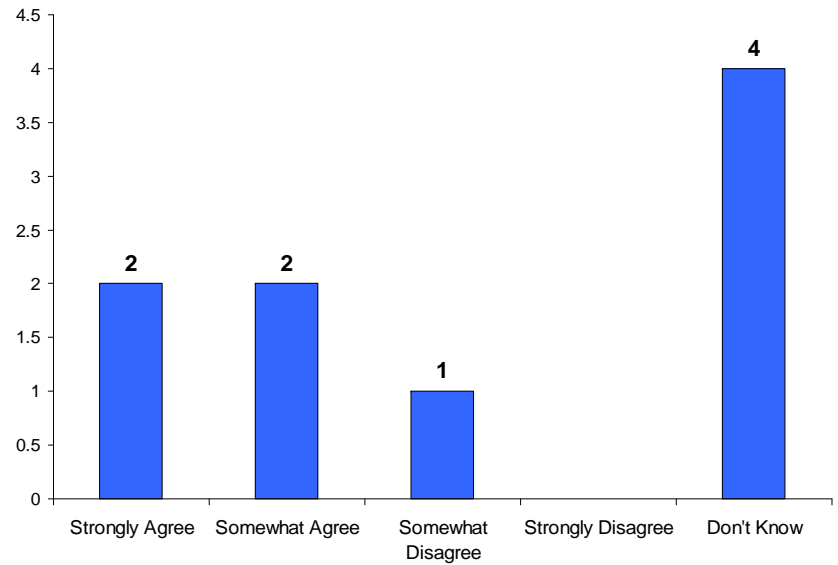
Legal Assistance

Figure 5.9: "Local LTCOPs Have the Legal Assistance for Resident Quality of Care and Rights"



Note: No informed respondent chose the "Strongly Disagree" response.

Figure 5.10: "Legal Assistance for Ombudsman Program Matters is Adequate"



Note: No informed respondent chose the "Strongly Disagree" response. One respondent did not answer the question.

This report provides detailed descriptions of LTCOPs in Ohio. It also contains analyses of survey items—both structured and open-ended—with all of the state’s regional program directors, and a purposive sample of informed respondents who, in various ways, have a role in shaping the functioning and effectiveness of the LTCOP. Finally, we make selective use of Ombudsman Documentation & Information System for Ohio (ODIS) data, i.e., data from Ohio’s mandated ombudsman on-line reporting/complaint system that has become something of a model for LTCOPs nationally. Our goal throughout has been to identify systemic issues and mechanisms that mediate the ability of paid LTCOP staff and volunteers to carry out their federal and state mandates. In funding the research, the Cleveland Foundation sought to advance two areas of programmatic commitment: health and social services, and successful aging. From our standpoint the LTCOP spans both. For the growing number of older Ohioans, the health care system will extend to community-based care and skilled nursing facilities that ideally allow for maximal quality of life, despite illness or disability. In turn, social gerontologists increasingly see that “quality of care” is a necessary but not sufficient condition for ensuring quality of life for those, of whatever age, who reside in care settings.

Thus, key assumptions underlying the study were: 1) that there are compelling humanitarian and public policy reasons for preserving and strengthening the LTCOP, given its importance in protecting those who require rehabilitation or long-term care due to chronic illness or disability; and 2) that Ohio is facing significant, if not alarming, demographic and fiscal pressures that are propelling the cost and quality of long-term care to the forefront of the public agenda. Demographic projections make clear that, as in the nation as a whole, Ohio is an aging state; this trend, driven by relatively low birth rates and falling age-specific death rates, is compounded by substantial out-migration of younger people from the state in recent years. Thus, the traditional reliance on familial/kin care will not by itself be sufficient to meet the state’s changing care demands.

In this context, the LTCOP is both an essential and low-cost means of providing education, oversight, mediation, and resolution for the many thousands of LTC residents, as well as for the public at large. The professionals who make up the LTCOP in Ohio are, despite comparatively modest compensation, highly committed and widely knowledgeable about matters bearing on quality of care. They are required to keep abreast of changes in federal and state laws and regulations; document and analyze data on the nature and resolution of resident complaints; and maintain cooperative, interdependent relationships with an extensive network of actors in health care, law enforcement, and the policy realm, in addition to their direct ties with volunteers, residents, and resident advocates.

In concluding it may be helpful to reiterate the major topical area that framed our research questions; these are not only relevant for Ohio, but provide bases for comparison with other state-level studies of the LTCOP which have been carried out since the Institute of Medicine study gave renewed impetus to research the program roughly a decade ago. These topical areas include: (1) *adequacy and control over resources*; (2) *organizational autonomy*; and (3) *inter-organizational relationships and coordination*.

Adequacy and control over resources—our study makes clear that regional LTCOPs do *not* report having adequate resources (funding or staff) to fulfill their broad mandate. We find, first, that there are fairly wide disparities in the budgets of local programs across service areas (PSAs), and these do not appear to be linked in any coherent way to local programs' demands or needs. It is not uncommon for program directors to divert time to the search for external grant dollars to fund a position or support a particular project; however, these sources of support are both temporary and unstable. Consequently, in a kind of triage, regional programs typically sacrifice broad systemic efforts—such as monitoring changes in laws and regulations, community education, and legislative advocacy—in the name of meeting the immediate demands of facility contact and mediating specific complaints. One is reminded of the metaphor of a good samaritan, fishing drowning people out of a river downstream while, upstream, more swimmers are drawn into the current. Regional programs have the knowledge and expertise to address resident rights and welfare issues *collectively*, and could potentially have a greater impact as such. However, current funding and staffing levels are not sufficient to allow such efforts.

Organizational autonomy—is generally present and uncontested for regional programs in Ohio. Whether housed in Area Agencies on Aging (as are roughly half of Ohio's programs) or in various non-profit or legal service agencies, we find there to be excellent support for, and commitment to, the mission of the LTCOP among host agencies. In fact, these conditions help to explain how, despite funding/staffing pressures, regional programs have been able to sustain their effectiveness and stability despite Ohio's increasing demand for LTC oversight. We do find real concern about the potential for conflicts of interest within AAAs that house both LTCOPs and funded-contract services (e.g., "PASSPORT") with which clients have a right to take issue.

Inter-organizational relationships and coordination—were generally found to be strong and constructive; this was true even where, as between LTCOPs and nursing home providers, one might expect there to be greater tension. Among the challenges that did emerge in this connection are: how to form stronger coalitions between LTCOPs and associations with similar agendas, in order to leverage efforts toward lobbying and public/legislative advocacy; and how to increase the visibility and impact of the LTCOP in the fast-growing domain of community-based and home health care.

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